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**UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF CALIFORNIA  
REDDING DIVISION**

COUNTY OF TEHAMA,  
a political subdivision of the  
State of California; THE PEOPLE  
OF THE STATE OF CALIFORNIA,  
acting by and through the COUNTY  
OF TEHAMA.

## Plaintiffs,

VS.

AMERISOURCEBERGEN DRUG CORPORATION; CARDINAL HEALTH, INC.; McKESSON CORPORATION; PURDUE PHARMA L.P.; PURDUE PHARMA, INC.; THE PURDUE FREDERICK COMPANY, INC.; TEVA PHARMACEUTICAL INDUSTRIES, LTD.; TEVA PHARMACEUTICALS USA, INC.; CEPHALON, INC.; JOHNSON & JOHNSON; JANSSEN PHARMACEUTICALS, INC.; ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC. n/k/a JANSSEN PHARMACEUTICALS, INC.; JANSSEN PHARMACEUTICA

Case No.: \_\_\_\_\_

**COMPLAINT FOR DAMAGES  
AND DEMAND FOR JURY  
TRIAL**

(1) Public Nuisance;  
 (2) Violations of Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. § 1961 et seq.;  
 (3) Violations of 18 U.S.C. § 1962 et seq.;  
 (4) Violations of the California False Advertising Act, Cal. Bus. & Prof. Code § 17500 et seq.;  
 (5) Negligent Misrepresentation;  
 (6) Fraud and Fraudulent Misrepresentation; and  
 (7) Unjust Enrichment.

1 INC. n/k/a JANSSEN  
2 PHARMACEUTICALS, INC.;  
3 NORAMCO, INC.; ENDO HEALTH  
4 SOLUTIONS INC.; ENDO  
5 PHARMACEUTICALS, INC.;  
6 ALLERGAN PLC f/k/a ACTAVIS  
7 PLS; WATSON  
8 PHARMACEUTICALS, INC. n/k/a  
9 ACTAVIS, INC.; WATSON  
10 LABORATORIES, INC.; ACTAVIS  
11 LLC; ACTAVIS PHARMA, INC. f/k/a  
12 WATSON PHARMA, INC.;  
MALLINCKRODT PLC;  
MALLINCKRODT LLC; INSYS  
THERAPEUTICS, INC; CVS  
HEALTH CORP.; THE KROGER CO.;  
RITE AID OF MARYLAND, INC.;  
THRIFTY PAYLESS, INC.;  
WALGREENS BOOTS ALLIANCE,  
INC.; and WAL-MART, INC.  
13  
14 Defendants.  
15

## Defendants.

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1        Plaintiffs, COUNTY OF TEHAMA, and THE PEOPLE OF THE STATE  
2 OF CALIFORNIA, acting by and through Tehama County Counsel, (collectively  
3 “Plaintiffs”) bring this Complaint against Defendants Purdue Pharma L.P.; Purdue  
4 Pharma, Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceutical  
5 Industries, LTD.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson &  
6 Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals,  
7 Inc. n/k/a Janssen Pharmaceuticals, Inc.; Janssen Pharmaceutica Inc. n/k/a Janssen  
8 Pharmaceuticals, Inc.; Noramco, Inc.; Endo Health Solutions, Inc.; Endo  
9 Pharmaceuticals, Inc.; Allergan PLC f/k/a Actavis PLS; Watson Pharmaceuticals,  
10 Inc. n/k/a Actavis, Inc.; Watson Laboratories, Inc.; Actavis, LLC; Actavis  
11 Pharma, Inc. f/k/a Watson Pharma, Inc.; Mallinckrodt PLC; Mallinckrodt LLC;  
12 Insys Therapeutics, Inc., McKesson Corporation; Cardinal Health, Inc.;  
13 AmerisourceBergen Drug Corporation, CVS Health Corporation; The Kroger Co.;  
14 Rite Aid of Maryland, Inc. d/b/a Rite Aid Mid-Atlantic Customer Support Center,  
15 Inc.; Thrifty Payless, Inc.; Walgreens Boots Alliance, Inc. a/k/a Walgreen Co.,  
16 and Wal-Mart Inc., f/k/a Wal-Mart Stores, Inc., (collectively “Defendants”) and  
17 allege as follows:

18                      **I. INTRODUCTION**

19        1. Plaintiffs bring this civil action to eliminate the hazard to public  
20 health and safety caused by the opioid epidemic, to abate the nuisance caused  
21 thereby, and to recoup monies that have been spent and will be spent because of  
22 Defendants’ false, deceptive and unfair marketing and/or unlawful diversion of  
23 prescription opioids.<sup>1</sup> Such economic damages were foreseeable to Defendants  
24 and were sustained because of Defendants’ intentional and/or unlawful actions  
25 and omissions.

26  
27  
28        <sup>1</sup> As used herein, the term “opioid” refers to the entire family of opiate drugs  
including natural, synthetic and semi-synthetic opiates.

2. Opioid analgesics are widely diverted and improperly used, and the widespread abuse of opioids has resulted in a national epidemic of opioid overdose deaths and addictions.<sup>2</sup>

3. The opioid epidemic is “directly related to the increasingly widespread misuse of powerful opioid pain medications.”<sup>3</sup>

4. Plaintiffs bring this suit against the manufacturers of prescription opioids. The manufacturers aggressively pushed highly addictive, dangerous opioids, falsely representing to doctors that patients would only rarely succumb to drug addiction. These pharmaceutical companies aggressively advertised to and persuaded doctors to prescribe highly addictive, dangerous opioids, turning patients into drug addicts for their own corporate profit. Such actions were intentional and/or unlawful.

5. Plaintiffs also bring this suit against the wholesale distributors of these highly addictive drugs. The distributors and manufacturers intentionally and/or unlawfully breached their legal duties under federal and state law to monitor, detect, investigate, refuse and report suspicious orders of prescription opiates.

## II. PARTIES

## A. PLAINTIFFS.

6. Plaintiffs, THE PEOPLE OF THE STATE OF CALIFORNIA (“The People”), acting by and through Tehama County Counsel Richard Stout, and TEHAMA COUNTY, CALIFORNIA, (“The County”), are authorized to bring the causes of action brought herein. The County is a body corporate and politic of the

<sup>2</sup> See Nora D. Volkow & A. Thomas McLellan, *Opioid Abuse in Chronic Pain—Misconceptions and Mitigation Strategies*, 374 N. Eng. J. Med. 1253 (2016).

<sup>3</sup> See Robert M. Califf et al., *A Proactive Response to Prescription Opioid Abuse*, 374 N. Eng. J. Med. 1480 (2016).

1 State of California. Cal. Gov't Code § 23003. The County is authorized to bring  
2 this action. Cal. Gov't Code § 23004(a).

3       7. The County is responsible for the public health, safety and welfare of  
4 its citizens.

5       8. The County has declared, *inter alia*, that opioid abuse, addiction,  
6 morbidity and mortality have created a serious public health and safety crisis, and  
7 is a public nuisance, and that the diversion of legally produced controlled  
8 substances into the illicit market causes or contributes to this public nuisance.

9       9. The distribution and diversion of opioids into California (“the  
10 State”), and into Tehama County and surrounding areas (collectively, “Plaintiffs’  
11 Community”), created the foreseeable opioid crisis and opioid public nuisance for  
12 which Plaintiffs here seek relief.

13      10. Plaintiffs directly and foreseeably sustained all economic damages  
14 alleged herein. Defendants’ conduct has exacted a financial burden for which the  
15 Plaintiffs seek relief. Categories of past and continuing sustained damages  
16 include, *inter alia*: (1) costs for providing medical care, additional therapeutic,  
17 and prescription drug purchases, and other treatments for patients suffering from  
18 opioid-related addiction or disease, including overdoses and deaths; (2) costs for  
19 providing treatment, counseling, and rehabilitation services; (3) costs for  
20 providing treatment of infants born with opioid-related medical conditions; (4)  
21 costs associated with law enforcement and public safety relating to the opioid  
22 epidemic; (5) costs associated with providing care for children whose parents  
23 suffer from opioid-related disability or incapacitation and (6) costs associated with  
24 The County having to repair and remake its infrastructure, property and systems  
25 that have been damaged by Defendants’ actions, including, *inter alia*, its property  
26 and systems to treat addiction and abuse, to respond to and manage an elevated  
27 level of crime, to treat injuries, and to investigate and process deaths in Plaintiffs’  
28

1 Community. These damages have been suffered, and continue to be suffered,  
2 directly by the Plaintiffs.

3       11. Plaintiffs also seek the means to abate the epidemic created by  
4 Defendants' wrongful and/or unlawful conduct.

5       12. The People have standing to bring an action for the opioid epidemic  
6 nuisance created by Defendants. Cal. Civ. Proc. Code § 731 ("A civil action may  
7 be brought in the name of the people of the State of California to abate a public  
8 nuisance, as defined in Section 3480 of the Civil Code, by the . . . county counsel  
9 of any county in which the nuisance exists.").

10      13. The County has standing to bring an action for damages incurred to  
11 its property by the public nuisance created by Defendants. Cal. Civ. Proc. Code §  
12 731 ("An action may be brought by any person whose property is injuriously  
13 affected, . . . and by the judgment in that action the nuisance may be enjoined or  
14 abated as well as damages recovered therefor.").

15      14. The People have standing to bring this claim for injunctive relief and  
16 civil penalties under the California False Advertising Act. Cal. Bus. & Prof. Code  
17 §§ 17535, 17536.

18      15. The County has standing to recover damages incurred as a result of  
19 Defendants' actions and omissions. Cal. Gov't Code § 23004(a). The County has  
20 standing to bring claims under the federal RICO statute, pursuant to 18 U.S.C. §  
21 1961(3) ("persons" include entities which can hold legal title to property) and 18  
22 U.S.C. § 1964 ("persons" have standing).

23      **B. DEFENDANTS.**

24       **1. Manufacturer Defendants.**

25      16. The Manufacturer Defendants are defined below. At all relevant  
26 times, the Manufacturer Defendants have packaged, distributed, supplied, sold,  
27 placed into the stream of commerce, labeled, described, marketed, advertised,  
28 promoted and purported to warn or purported to inform prescribers and users

1 regarding the benefits and risks associated with the use of the prescription opioid  
2 drugs. The Manufacturer Defendants, at all times, have manufactured and sold  
3 prescription opioids without fulfilling their legal duty to prevent diversion and  
4 report suspicious orders.

5       17. PURDUE PHARMA L.P. is a limited partnership organized under  
6 the laws of Delaware. PURDUE PHARMA INC. is a New York corporation with  
7 its principal place of business in Stamford, Connecticut, and THE PURDUE  
8 FREDERICK COMPANY, INC. is a Delaware corporation with its principal  
9 place of business in Stamford, Connecticut (collectively, “Purdue”).

10      18. Purdue manufactures, promotes, sells, and distributes opioids such as  
11 OxyContin, MS Contin, Dilaudid/Dilaudid HP, Butrans, Hysingla ER, and  
12 Targiniq ER in the United States. OxyContin is Purdue’s best-selling opioid.  
13 Since 2009, Purdue’s annual nationwide sales of OxyContin have fluctuated  
14 between \$2.47 billion and \$2.99 billion, up four-fold from its 2006 sales of \$800  
15 million. OxyContin constitutes roughly 30% of the entire market for analgesic  
16 drugs (painkillers).

17      19. CEPHALON, INC. is a Delaware corporation with its principal place  
18 of business in Frazer, Pennsylvania. TEVA PHARMACEUTICAL  
19 INDUSTRIES, LTD. (“Teva Ltd.”) is an Israeli corporation with its principal  
20 place of business in Petah Tikva, Israel. In 2011, Teva Ltd. acquired Cephalon,  
21 Inc. TEVA PHARMACEUTICALS USA, INC. (“Teva USA”) is a Delaware  
22 corporation and is a wholly owned subsidiary of Teva Ltd. in Pennsylvania. Teva  
23 USA acquired Cephalon in October 2011.

24      20. Cephalon, Inc. manufactures, promotes, sells, and distributes opioids  
25 such as Actiq and Fentora in the United States. Actiq has been approved by the  
26 FDA only for the “management of breakthrough cancer pain in patients 16 years  
27 and older with malignancies who are already receiving and who are tolerant to  
28

1 around-the-clock opioid therapy for the underlying persistent cancer pain.”<sup>4</sup>  
 2 Fentora has been approved by the FDA only for the “management of breakthrough  
 3 pain in cancer patients 18 years of age and older who are already receiving and  
 4 who are tolerant to around-the-clock opioid therapy for their underlying persistent  
 5 cancer pain.”<sup>5</sup> In 2008, Cephalon pled guilty to a criminal violation of the Federal  
 6 Food, Drug and Cosmetic Act for its misleading promotion of Actiq and two other  
 7 drugs, and agreed to pay \$425 million.<sup>6</sup>

8       21. Teva Ltd., Teva USA, and Cephalon, Inc. work together closely to  
 9 market and sell Cephalon products in the United States. Teva Ltd. conducts all  
 10 sales and marketing activities for Cephalon in the United States through Teva  
 11 USA and has done so since its October 2011 acquisition of Cephalon. Teva Ltd.  
 12 and Teva USA hold out Actiq and Fentora as Teva products to the public. Teva  
 13 USA sells all former Cephalon branded products through its “specialty medicines”  
 14 division. The FDA-approved prescribing information and medication guide, which  
 15 is distributed with Cephalon opioids, discloses that the guide was submitted by  
 16 Teva USA, and directs physicians to contact Teva USA to report adverse events.

17       22. All of Cephalon’s promotional websites, including those for Actiq  
 18 and Fentora, display Teva Ltd.’s logo.<sup>7</sup> Teva Ltd.’s financial reports list  
 19 Cephalon’s and Teva USA’s sales as its own, and its year-end report for 2012 –  
 20 the year immediately following the Cephalon acquisition – attributed a 22%

21  
 22       <sup>4</sup> *Highlights of Prescribing Information, ACTIQ® (fentanyl citrate) oral*  
 23 *transmucosal lozenge, CII* (2009),  
[https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2009/020747s030lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/020747s030lbl.pdf).

24       <sup>5</sup> *Highlights of Prescribing Information, FENTORA® (fentanyl citrate) buccal*  
 25 *tablet, CII* (2011),  
[https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2012/021947s015lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/021947s015lbl.pdf).

26       <sup>6</sup> Press Release, U.S. Dep’t of Justice, Biopharmaceutical Company, Cephalon, to  
 27 Pay \$425 Million & Enter Plea to Resolve Allegations of Off-Label Marketing  
 28 (Sept. 29, 2008), <https://www.justice.gov/archive/opa/pr/2008/September/08-civ-860.html>.

<sup>7</sup> E.g., ACTIQ, <http://www.actiq.com/> (displaying logo at bottom-left) (last visited Jan. 16, 2018).

1 increase in its specialty medicine sales to “the inclusion of a full year of  
 2 Cephalon’s specialty sales,” including *inter alia* sales of Fentora®.<sup>8</sup> Through  
 3 interrelated operations like these, Teva Ltd. operates in the United States through  
 4 its subsidiaries Cephalon and Teva USA. The United States is the largest of Teva  
 5 Ltd.’s global markets, representing 53% of its global revenue in 2015, and, were it  
 6 not for the existence of Teva USA and Cephalon, Inc., Teva Ltd. would conduct  
 7 those companies’ business in the United States itself. Upon information and  
 8 belief, Teva Ltd. directs the business practices of Cephalon and Teva USA, and  
 9 their profits inure to the benefit of Teva Ltd. as controlling shareholder. Teva  
 10 Pharmaceutical Industries, Ltd., Teva Pharmaceuticals USA, Inc., and Cephalon,  
 11 Inc. are referred to as “Cephalon.”

12       23. JANSSEN PHARMACEUTICALS, INC. is a Pennsylvania  
 13 corporation with its principal place of business in Titusville, New Jersey, and is a  
 14 wholly owned subsidiary of JOHNSON & JOHNSON (J&J), a New Jersey  
 15 corporation with its principal place of business in New Brunswick, New Jersey.  
 16 NORAMCO, INC. (“Noramco”) is a Delaware company headquartered in  
 17 Wilmington, Delaware and was a wholly owned subsidiary of J&J until July 2016.  
 18 ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., now known as  
 19 JANSSEN PHARMACEUTICALS, INC., is a Pennsylvania corporation with its  
 20 principal place of business in Titusville, New Jersey. JANSSEN  
 21 PHARMACEUTICA INC., now known as JANSSEN PHARMACEUTICALS,  
 22 INC., is a Pennsylvania corporation with its principal place of business in  
 23 Titusville, New Jersey. J&J is the only company that owns more than 10% of  
 24 Janssen Pharmaceuticals’ stock, and corresponds with the FDA regarding  
 25 Janssen’s products. Upon information and belief, J&J controls the sale and  
 26

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27       28       <sup>8</sup> Teva Ltd., Annual Report (Form 20-F) 62 (Feb. 12, 2013),  
 http://annualreports.com/HostedData/AnnualReportArchive/t/NASDAQ\_TEVA\_2  
 012.pdf.

1 development of Janssen Pharmaceuticals' drugs and Janssen's profits inure to  
2 J&J's benefit. Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen  
3 Pharmaceuticals, Inc., Janssen Pharmaceutica, Inc., Noramco, and J&J are  
4 referred to as "Janssen."

5       24. Janssen manufactures, promotes, sells, and distributes drugs in the  
6 United States, including the opioid Duragesic (fentanyl). Before 2009, Duragesic  
7 accounted for at least \$1 billion in annual sales. Until January 2015, Janssen  
8 developed, marketed, and sold the opioids Nucynta (tapentadol) and Nucynta ER.  
9 Together, Nucynta and Nucynta ER accounted for \$172 million in sales in 2014.

10      25. ENDO HEALTH SOLUTIONS INC. is a Delaware corporation with  
11 its principal place of business in Malvern, Pennsylvania. ENDO  
12 PHARMACEUTICALS INC. is a wholly owned subsidiary of Endo Health  
13 Solutions Inc. and is a Delaware corporation with its principal place of business in  
14 Malvern, Pennsylvania. Endo Health Solutions Inc. and Endo Pharmaceuticals  
15 Inc. are referred to as "Endo."

16      26. Endo develops, markets, and sells prescription drugs, including the  
17 opioids Opana/Opana ER, Percodan, Percocet, and Zydome, in the United States.  
18 Opioids made up roughly \$403 million of Endo's overall revenues of \$3 billion in  
19 2012. Opana ER yielded \$1.15 billion in revenue from 2010 and 2013, and it  
20 accounted for 10% of Endo's total revenue in 2012. Endo also manufactures and  
21 sells generic opioids such as oxycodone, oxymorphone, hydromorphone, and  
22 hydrocodone products in the United States, by itself and through its subsidiary,  
23 Qualitest Pharmaceuticals, Inc.

24      27. ALLERGAN PLC is a public limited company incorporated in  
25 Ireland with its principal place of business in Dublin, Ireland. ACTAVIS PLC  
26 acquired ALLERGAN PLC in March 2015, and the combined company changed  
27 its name to ALLERGAN PLC in January 2013. Before that, WATSON  
28 PHARMACEUTICALS, INC. acquired ACTAVIS, INC. in October 2012, and

1 the combined company changed its name to Actavis, Inc. as of January 2013 and  
 2 then ACTAVIS PLC in October 2013. WATSON LABORATORIES, INC. is a  
 3 Nevada corporation with its principal place of business in Corona, California, and  
 4 is a wholly-owned subsidiary of ALLERGAN PLC (f/k/a Actavis, Inc., f/k/a  
 5 Watson Pharmaceuticals, Inc.). ACTAVIS PHARMA, INC. (f/k/a Actavis, Inc.) is  
 6 a Delaware corporation with its principal place of business in New Jersey and was  
 7 formerly known as WATSON PHARMA, INC. ACTAVIS LLC is a Delaware  
 8 limited liability company with its principal place of business in Parsippany, New  
 9 Jersey. Each of these defendants is owned by ALLERGAN PLC, which uses them  
 10 to market and sell its drugs in the United States. Upon information and belief,  
 11 ALLERGAN PLC exercises control over these marketing and sales efforts and  
 12 profits from the sale of Allergan/Actavis products ultimately inure to its benefit.  
 13 ALLERGAN PLC, ACTAVIS PLC, ACTAVIS, Inc., Actavis LLC, Actavis  
 14 Pharma, Inc., Watson Pharmaceuticals, Inc., Watson Pharma, Inc., and Watson  
 15 Laboratories, Inc. are referred to as "Actavis."

16       28. Actavis manufactures, promotes, sells, and distributes opioids,  
 17 including the branded drugs Kadian and Norco, a generic version of Kadian, and  
 18 generic versions of Duragesic and Opana, in the United States. Actavis acquired  
 19 the rights to Kadian from King Pharmaceuticals, Inc. on December 30, 2008, and  
 20 began marketing Kadian in 2009.

21       29. MALLINCKRODT, PLC is an Irish public limited company  
 22 headquartered in Staines-upon-Thames, United Kingdom, with its U.S.  
 23 headquarters in St. Louis, Missouri. MALLINCKRODT, LLC is a limited liability  
 24 company organized and existing under the laws of the State of Delaware.  
 25 Mallinckrodt, LLC is a wholly owned subsidiary of Mallinckrodt, PLC.  
 26 Mallinckrodt, PLC and Mallinckrodt, LLC are referred to as "Mallinckrodt."

27       30. Mallinckrodt manufactures, markets, and sells drugs in the United  
 28 States including generic oxycodone, of which it is one of the largest

1 manufacturers. In July 2017 Mallinckrodt agreed to pay \$35 million to settle  
2 allegations brought by the Department of Justice that it failed to detect and notify  
3 the DEA of suspicious orders of controlled substances.

4       31. INSYS THERAPEUTICS, INC. is a Delaware corporation with its  
5 principal place of business in Chandler, Arizona. Insys's principal product and  
6 source of revenue is Subsys.

7       32. Insys made thousands of payments to physicians nationwide,  
8 including in the State, ostensibly for activities including participating on speakers'  
9 bureaus, providing consulting services, assisting in post-marketing safety  
10 surveillance and other services, but in fact to deceptively promote and maximize  
11 the use of opioids.

12       33. Subsys is a transmucosal immediate-release formulation (TIRF) of  
13 fentanyl, contained in a single-dose spray device intended for oral, under the  
14 tongue administration. Subsys was approved by the FDA solely for the treatment  
15 of breakthrough cancer pain.

16       34. In 2016, Insys made approximately \$330 million in net revenue from  
17 Subsys. Insys promotes, sells, and distributes Subsys throughout the United  
18 States, the County, and Plaintiffs' Community.

19       35. Insys's founder and owner was recently arrested and charged, along  
20 with other Insys executives, with multiple felonies in connection with an alleged  
21 conspiracy to bribe practitioners to prescribe Subsys and defraud insurance  
22 companies. Other Insys executives and managers were previously indicted.

23           **2. Distributor Defendants.**

24       36. The Distributor Defendants also are defined below. At all relevant  
25 times, the Distributor Defendants have distributed, supplied, sold, and placed into  
26 the stream of commerce the prescription opioids, without fulfilling the  
27 fundamental duty of wholesale drug distributors to detect and warn of diversion of  
28 dangerous drugs for non-medical purposes. The Distributor Defendants

1 universally failed to comply with federal and/or state law. The Distributor  
2 Defendants are engaged in “wholesale distribution,” as defined under state and  
3 federal law. Plaintiffs allege the unlawful conduct by the Distributor Defendants is  
4 responsible for the volume of prescription opioids plaguing Plaintiffs’  
5 Community.

6 37. McKESSON CORPORATION (“McKesson”) at all relevant times,  
7 operated as a licensed distributor in California, licensed by the California State  
8 Board of Pharmacy and holding both wholesaler and out of state wholesaler  
9 distributor licenses. McKesson is a Delaware corporation. McKesson has its  
10 principal place of business located in San Francisco, California. McKesson  
11 operates distribution centers in Chino, Fullerton, Sacramento and Visalia,  
12 California.

13 38. CARDINAL HEALTH, INC. (“Cardinal”) at all relevant times,  
14 operated as a licensed distributor in California, licensed by the California State  
15 Board of Pharmacy and holding both wholesaler and out of state wholesaler  
16 distributor licenses. Cardinal’s principal office is located in Dublin, Ohio.  
17 Cardinal operates a distribution center in Sacramento, California.

18 39. AMERISOURCEBERGEN DRUG CORPORATION  
19 (“AmerisourceBergen”) at all relevant times, operated as a licensed distributor in  
20 California, licensed by the California State Board of Pharmacy and holding both  
21 wholesaler and out of state wholesaler distributor licenses. AmerisourceBergen is  
22 a Delaware corporation and its principal place of business is located in  
23 Chesterbrook, Pennsylvania.

24 40. Defendant CVS HEALTH CORPORATION is a Delaware  
25 corporation with its principal place of business in Rhode Island. CVS Health  
26 Corporation conducts business as a licensed wholesale distributor under the  
27 following named business entities: CVS Indiana, L.L.C.; CVS Orlando FL  
28 Distribution; CVS Pharmacy, Inc.; CVS RX Services, Inc, d/b/a CVS Pharmacy

1 Distribution Center; CVS TN Distribution, LLC ; and CVS VERO FL  
2 Distribution, L.L.C (collectively “CVS”). At all times relevant to this Complaint,  
3 CVS distributed prescription opioids throughout the United States, including in  
4 the State and the County and Plaintiffs’ Community specifically. At all relevant  
5 times, this Defendant operated as a licensed distributor in California, licensed by  
6 the California State Board of Pharmacy.

7       41. Defendant THE KROGER CO. is an Ohio corporation with  
8 headquarters in Cincinnati, OH. Kroger operates 2,268 pharmacies in the United  
9 States, including in California. The Kroger Co. conducts business as a licensed  
10 wholesale distributor under the following named business entities: Kroger Limited  
11 Partnership I and Kroger Limited Partnership II (collectively “Kroger”). At all  
12 times relevant to this Complaint, Kroger distributed and dispensed prescription  
13 opioids throughout the United States, including in California and Plaintiffs’  
14 Community specifically. At all relevant times, this Defendant operated licensed  
15 pharmacies in California, licensed by the California State Board of Pharmacy.

16       42. Defendant RITE AID OF MARYLAND, INC., d/b/a Rite Aid Mid-  
17 Atlantic Customer Support Center, Inc. is a Maryland corporation with its  
18 principal office located in Camp Hill, Pennsylvania and is a subsidiary of Rite Aid  
19 Corporation. Defendant THRIFTY PAYLESS, INC. is a California corporation  
20 with its principal office in located in Camp Hill, Pennsylvania and is a subsidiary  
21 of Rite Aid Corporation. Rite Aid of Maryland, Inc., d/b/a as Rite Aid Mid-  
22 Atlantic Customer Support Center, Inc. and Thrifty Payless, Inc. are referred to as  
23 “Rite Aid.” At all times relevant to this Complaint, Rite Aid distributed  
24 prescription opioids throughout the United States, including in the State, the  
25 County and Plaintiffs’ Community specifically. Rite Aid of Maryland, Inc., d/b/a  
26 Rite Aid Mid-Atlantic Customer Support Center, Inc. conducts business as a  
27 licensed wholesale distributor under the name Rite Aid Mid-Atlantic Customer  
28 Support Center and at all relevant times, operated as a licensed distributor in

1 California, licensed by the California State of Pharmacy. Thrifty Payless, Inc.  
2 conducts business as a licensed wholesale distributor and at all relevant times,  
3 operated as a licensed distributor in California, licensed by the California State of  
4 Pharmacy.

5       43. Defendant WALGREENS BOOTS ALLIANCE, INC., also known  
6 as Walgreen Co. (“Walgreens”) is a Delaware corporation with its principal place  
7 of business in Illinois. Walgreens Boots Alliance Inc. conducts business as a  
8 licensed wholesale distributor under the following named business entities:  
9 Walgreen Co.; Walgreen Eastern Co., Inc.; Walgreen Arizona Drug Co.  
10 (collectively “Walgreens”). At all times relevant to this Complaint, Walgreens  
11 distributed prescription opioids throughout the United States, including in the  
12 State, the County and Plaintiffs’ Community specifically. At all relevant times,  
13 this Defendant operated as a licensed distributor in California, licensed by the  
14 California State Board of Pharmacy.

15       44. Defendant WAL-MART INC., formerly known as Wal-Mart Stores,  
16 Inc. (“Wal-Mart”), is a Delaware corporation with its principal place of business  
17 in Arkansas. At all times relevant to this Complaint, Wal-Mart distributed  
18 prescription opioids throughout the United States, including in the State, the  
19 County and Plaintiffs’ Community specifically. Wal-Mart Stores, Inc. conducts  
20 business as a licensed wholesale distributor under the following named business  
21 entities: Wal-Mart Warehouse #28; Wal-Mart Warehouse #6045 aka Wal-Mart  
22 Warehouse #45; Wal-Mart Warehouse # 6046 aka Wal-Mart Warehouse #46  
23 (“collectively “Wal-Mart”). At all relevant times, this Defendant operated as a  
24 licensed distributor in California, licensed by the California State Board of  
25 Pharmacy.

26       45. Collectively, Defendants CVS, Kroger, Rite Aid, Walgreens, Wal-  
27 Mart are referred to as “National Retail Pharmacies.” Cardinal, McKesson,  
28

1 AmerisourceBergen, and the National Retail Pharmacies are collectively referred  
2 to as the “Distributor Defendants.”

3       46. Defendants include the above referenced entities as well as their  
4 predecessors, successors, affiliates, subsidiaries, partnerships and divisions to the  
5 extent that they are engaged in the manufacture, promotion, distribution, sale  
6 and/or dispensing of opioids.

### **III. JURISDICTION & VENUE**

8       47. This Court has subject matter jurisdiction under 28 U.S.C. § 1331  
9 based upon the federal claims asserted under the Racketeer Influenced and  
10 Corrupt Organizations Act, 18 U.S.C. § 1961, *et seq.* (“RICO”). This Court has  
11 supplemental jurisdiction over Plaintiffs’ state law claims pursuant to 28 U.S.C. §  
12 1367 because those claims are so related to Plaintiffs’ federal claims that they  
13 form part of the same case or controversy.

14       48. This Court has personal jurisdiction over Defendants because they  
15 conduct business in the State, purposefully direct or directed their actions toward  
16 the State, some or all consented to be sued in the State by registering an agent for  
17 service of process, they consensually submitted to the jurisdiction of the State  
18 when obtaining a manufacturer or distributor license, and because they have the  
19 requisite minimum contacts with the State necessary to constitutionally permit the  
20 Court to exercise jurisdiction.

21       49. This Court also has personal jurisdiction over all of the defendants  
22 under 18 U.S.C. § 1965(b). This Court may exercise nation-wide jurisdiction over  
23 the named Defendants where the “ends of justice” require national service and  
24 Plaintiffs demonstrate national contacts. Here, the interests of justice require that  
25 Plaintiffs be allowed to bring all members of the nationwide RICO enterprise  
26 before the court in a single trial. *See, e.g., Iron Workers Local Union No. 17*  
27 *Insurance Fund v. Philip Morris Inc.*, 23 F. Supp. 2d 796, 803 (N.D. Ohio 1998)  
28 (citing *LaSalle National Bank v. Arroyo Office Plaza, Ltd.*, 1988 WL 23824, \*2

1 (N.D. Ill. Mar 10, 1988); *Butcher's Union Local No. 498 v. SDC Invest., Inc.*, 788  
2 F.2d 535, 539 (9th Cir. 1986)).

3       50.   Venue is proper in this District pursuant to 28 U.S.C. § 1391 and 18  
4 U.S.C. §1965 because a substantial part of the events or omissions giving rise to  
5 the claim occurred in this District and each Defendant transacted affairs and  
6 conducted activity that gave rise to the claim of relief in this District. 28 U.S.C. §  
7 1391(b); 18 U.S.C. §1965(a).

8                          **IV. FACTUAL BACKGROUND**

9                          **A. THE OPIOID EPIDEMIC.**

10                         **1. The National Opioid Epidemic.**

11        51.   The past two decades have been characterized by increasing abuse  
12 and diversion of prescription drugs, including opioid medications, in the United  
13 States.<sup>9</sup>

14        52.   Prescription opioids have become widely prescribed. By 2010,  
15 enough prescription opioids were sold to medicate every adult in the United States  
16 with a dose of 5 milligrams of hydrocodone every 4 hours for 1 month.<sup>10</sup>

17        53.   By 2011, the U.S. Department of Health and Human Resources,  
18 Centers for Disease Control and Prevention, declared prescription painkiller  
19 overdoses at epidemic levels. The News Release noted:

- 20                         a. The death toll from overdoses of prescription painkillers has more  
21 than tripled in the past decade.  
22                         b. More than 40 people die every day from overdoses involving narcotic  
23 pain relievers like hydrocodone (Vicodin), methadone, oxycodone  
(OxyContin), and oxymorphone (Opana).  
24                         c. Overdoses involving prescription painkillers are at epidemic levels  
25 and now kill more Americans than heroin and cocaine combined.

26                         <sup>9</sup> See Richard C. Dart et al., Trends in Opioid Analgesic Abuse and Mortality in the  
27 United States, 372 N. Eng. J. Med. 241 (2015).

28                         <sup>10</sup> Katherine M. Keyes et al., Understanding the Rural-Urban Differences in  
Nonmedical Prescription Opioid Use and Abuse in the United States, 104 Am. J.  
Pub. Health e52 (2014).

- 1           d. The increased use of prescription painkillers for nonmedical reasons,  
2           along with growing sales, has contributed to a large number of  
3           overdoses and deaths. In 2010, 1 in every 20 people in the United  
4           States age 12 and older—a total of 12 million people—reported using  
5           prescription painkillers non-medically according to the National  
6           Survey on Drug Use and Health. Based on the data from the Drug  
7           Enforcement Administration, sales of these drugs to pharmacies and  
8           health care providers have increased by more than 300 percent since  
9           1999.
- 10           e. Prescription drug abuse is a silent epidemic that is stealing thousands  
11           of lives and tearing apart communities and families across America.
- 12           f. Almost 5,500 people start to misuse prescription painkillers every  
13           day.<sup>11</sup>

14           54. The number of annual opioid prescriptions written in the United  
15           States is now roughly equal to the number of adults in the population.<sup>12</sup>

16           55. Many Americans are now addicted to prescription opioids, and the  
17           number of deaths due to prescription opioid overdose is unacceptable. In 2016,  
18           drug overdoses killed roughly 64,000 people in the United States, an increase of  
19           more than 22 percent over the 52,404 drug deaths recorded the previous year.<sup>13</sup>

20           56. Moreover, the CDC has identified addiction to prescription pain  
21           medication as the strongest risk factor for heroin addiction. People who are  
22           addicted to prescription opioid painkillers are forty times more likely to be  
23           addicted to heroin.<sup>14</sup>

24           57. Heroin is pharmacologically similar to prescription opioids. The  
25           majority of current heroin users report having used prescription opioids non-

26           <sup>11</sup> See Press Release, Ctrs. for Disease Control and Prevention, U.S. Dep’t of  
27           Health and Human Servs., Prescription Painkiller Overdoses at Epidemic Levels  
28           (Nov. 1, 2011),  
[https://www.cdc.gov/media/releases/2011/p1101\\_flu\\_pain\\_killer\\_overdose.html](https://www.cdc.gov/media/releases/2011/p1101_flu_pain_killer_overdose.html).

29           <sup>12</sup> See Robert M. Califf et al., *A Proactive Response to Prescription Opioid Abuse*,  
30           374 N. Eng. J. Med. 1480 (2016).

31           <sup>13</sup> See Ctrs. for Disease Control and Prevention, U.S. Dep’t of Health and Human  
32           Servs., Provisional Counts of Drug Overdose Deaths, (August 8, 2016),  
[https://www.cdc.gov/nchs/data/health\\_policy/monthly-drug-overdose-death-estimates.pdf](https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf).

33           <sup>14</sup> See Ctrs. for Disease Control and Prevention, U.S. Dep’t of Health and Human  
34           Servs., *Today’s Heroin Epidemic*,  
<https://www.cdc.gov/vitalsigns/heroin/index.html> (last updated July 7, 2015).

1 medically before they initiated heroin use. Available data indicates that the  
 2 nonmedical use of prescription opioids is a strong risk factor for heroin use.<sup>15</sup>

3       58. The CDC reports that drug overdose deaths involving heroin  
 4 continued to climb sharply, with heroin overdoses more than tripling in 4 years.  
 5 This increase mirrors large increases in heroin use across the country and has been  
 6 shown to be closely tied to opioid pain reliever misuse and dependence. ***Past***  
 7 ***misuse of prescription opioids is the strongest risk factor for heroin initiation***  
 8 ***and use,*** specifically among persons who report past-year dependence or abuse.  
 9 The increased availability of heroin, combined with its relatively low price  
 10 (compared with diverted prescription opioids) and high purity appear to be major  
 11 drivers of the upward trend in heroin use and overdose.<sup>16</sup>

12       59. The societal costs of prescription drug abuse are “huge.”<sup>17</sup>

13       60. Across the nation, local governments are struggling with a  
 14 pernicious, ever-expanding epidemic of opioid addiction and abuse. Every day,  
 15 more than 90 Americans lose their lives after overdosing on opioids.<sup>18</sup>

16       61. The National Institute on Drug Abuse identifies misuse and addiction  
 17 to opioids as “a serious national crisis that affects public health as well as social  
 18 and economic welfare.”<sup>19</sup> The economic burden of prescription opioid misuse  
 19

20       <sup>15</sup> See Wilson M. Compton, Relationship Between Nonmedical Prescription-  
 21 Opioid Use and Heroin, 374 N. Eng. J. Med. 154 (2016).

22       <sup>16</sup> See Rose A. Rudd et al., *Increases in Drug and Opioid Overdose Deaths—*  
 23 *United States, 2000–2014*, 64 Morbidity & Mortality Wkly. Rep. 1378 (2016).

24       <sup>17</sup> See Amicus Curiae Brief of Healthcare Distribution Management Association in  
 25 Support of Appellant Cardinal Health, Inc., *Cardinal Health, Inc. v. United States*  
 26 *Dept. Justice*, No. 12-5061 (D.C. Cir. May 9, 2012), 2012 WL 1637016, at \*10  
 27 [hereinafter Brief of HDMA].

28       <sup>18</sup> Opioid Crisis, NIH, National Institute on Drug Abuse (available at  
 https://www.drugabuse.gov/drugs-abuse/opioids/opioid-crisis, last visited Sept. 19,  
 2017) (“Opioid Crisis, NIH”) (citing at note 1 Rudd RA, Seth P, David F, Scholl L,  
 29 *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–*  
*2015*, MMWR MORB MORTAL WKLY REP. 2016;65,  
 doi:10.15585/mmwr.mm655051e1).

30       <sup>19</sup> Opioid Crisis, NIH.

1 alone is \$78.5 billion a year, including the costs of healthcare, lost productivity,  
 2 addiction treatment, and criminal justice expenditures.<sup>20</sup>

3       62. The U.S. opioid epidemic is continuing, and drug overdose deaths  
 4 nearly tripled during 1999–2014. Among 47,055 drug overdose deaths that  
 5 occurred in 2014 in the United States, 28,647 (60.9%) involved an opioid.<sup>21</sup>

6       63. The rate of death from opioid overdose has quadrupled during the  
 7 past 15 years in the United States. Nonfatal opioid overdoses that require medical  
 8 care in a hospital or emergency department have increased by a factor of six in the  
 9 past 15 years.<sup>22</sup>

10      64. Every day brings a new revelation regarding the depth of the opioid  
 11 plague: just to name one example, the New York Times reported in September  
 12 2017 that the epidemic, which now claims 60,000 lives a year, is now killing  
 13 babies and toddlers because ubiquitous, deadly opioids are “everywhere” and  
 14 mistaken as candy.<sup>23</sup>

15      65. In 2016, the President of the United States declared an opioid and  
 16 heroin epidemic.<sup>24</sup>

17      66. The epidemic of prescription pain medication and heroin deaths is  
 18 devastating families and communities across the country.<sup>25</sup> Meanwhile, the  
 19  
 20

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21      <sup>20</sup> *Id.* (citing at note 2 Florence CS, Zhou C, Luo F, Xu L, *The Economic Burden*  
 22 *of Prescription Opioid Overdose, Abuse, and Dependence in the United States,*  
 23 2013, MED CARE 2016;54(10):901-906, doi:10.1097/MLR.0000000000000625).

24      <sup>21</sup> See Rose A. Rudd et al., Increases in Drug and Opioid-Involved Overdose  
 25 Deaths—United States, 2010–2015, 65 Morbidity & Mortality Wkly. Rep. 1445  
 26 (2016).

27      <sup>22</sup> See Nora D. Volkow & A. Thomas McLellan, *Opioid Abuse in Chronic Pain—*  
 28 *Misconceptions and Mitigation Strategies*, 374 N. Eng. J. Med. 1253 (2016).

29      <sup>23</sup> Julie Turkewitz, ‘The Pills are Everywhere’: How the Opioid Crisis Claims Its  
 30 Youngest Victims, N.Y. Times, Sept. 20, 2017 (“‘It’s a cancer,’ said [grandmother  
 31 of dead one-year old], of the nation’s opioid problem, ‘with tendrils that are going  
 32 everywhere.’”).

33      <sup>24</sup> See Proclamation No. 9499, 81 Fed. Reg. 65,173 (Sept. 16, 2016) (proclaiming  
 34 “Prescription Opioid and Heroin Epidemic Awareness Week”).

1 manufacturers and distributors of prescription opioids extract billions of dollars of  
 2 revenue from the addicted American public while public entities experience  
 3 hundreds of millions of dollars of injury – if not more – caused by the reasonably  
 4 foreseeable consequences of the prescription opioid addiction epidemic.

5       67. The prescription opioid manufacturers and distributors, including the  
 6 Defendants, have continued their wrongful, intentional, and unlawful conduct,  
 7 despite their knowledge that such conduct is causing and/or contributing to the  
 8 national, state, and local opioid epidemic.

9           **2. The California Opioid Epidemic.**

10       68. California has been especially ravaged by the national opioid crisis.

11       69. More people die each year from drug overdoses in California than in  
 12 any other state.<sup>26</sup> The State's death rate has continued to climb, increasing by 30  
 13 percent from 1999 to 2015, according to the Center for Disease Control (CDC).<sup>27</sup>

14       70. In 2016, 1,925 Californians died due to prescription opioids.<sup>28</sup> This  
 15 number is on par with other recent years: in 2015, 1,966 deaths in California were  
 16 due just to prescription opioids (not including heroin); in 2014 that number was  
 17 even higher at 2,024 prescription opioid deaths; and in 2013, 1,934 Californians  
 18 died from a prescription opioid overdose.<sup>29</sup>

19  
 20       <sup>25</sup> See Presidential Memorandum – Addressing Prescription Drug Abuse and  
 21 Heroin Use, 2015 Daily Comp. Pres. Doc. 743 (Oct. 21, 2015),  
<https://www.gpo.gov/fdsys/pkg/DCPD-201500743/pdf/DCPD-201500743.pdf>.

22       <sup>26</sup> Kristina Davis, “How California ranks in the nation’s opioid epidemic,” *The San*  
 23 *Diego Union-Tribune* (Nov. 8, 2017) available at  
<http://www.sandiegouniontribune.com/news/health/sd-me-opioid-conference-20171108-story.html> (last visited March 2, 2018).

24       <sup>27</sup> Soumya Karlamangla, “California’s opioid death rate is among the national’s  
 25 lowest. Experts aren’t sure why,” *The Los Angeles Times* (Oct. 27, 2017) available  
 26 at <http://www.latimes.com/health/la-me-ln-california-opioids-20171026-htmlstory.html> (last visited March 2, 2018).

27       <sup>28</sup> Davis, *supra*.

28       <sup>29</sup> California Department of Public Health, *California Opioid Overdose*  
*Surveillance Dashboard*, available at [https://pdop.shinyapps.io/ODdash\\_v1/](https://pdop.shinyapps.io/ODdash_v1/) (last  
 visited March 2, 2018).

1       71. Of the 1,925 opioid-related deaths in California in 2016, fentanyl was  
2 a factor in at least 234 of them.<sup>30</sup> This is an increase of 47 percent for 2016.<sup>31</sup>  
3 Heroin-related deaths have risen by 67 percent in California since 2006.<sup>32</sup>

4       72. The high number of deaths are due in part to the extraordinary  
5 number of opioids prescribed in the State. Over 23.6 million prescriptions for  
6 opioids were written in California in just 2016.<sup>33</sup>

7       73. The California Department of Public Health tracks the number of  
8 reported hospitalizations and emergency department visits due to prescription  
9 opioids.<sup>34</sup> In 2015, the last year for which information is currently available,  
10 California had 3,935 emergency department visits and 4,095 hospitalizations  
11 related to prescription opioid overdoses (excluding heroin).<sup>35</sup> The numbers were  
12 even higher in 2014, when 4,106 people visited the emergency department and  
13 4,482 people were hospitalized due to prescription opioid abuse.<sup>36</sup> In 2013, there  
14 were 3,964 emergency department visits and 4,344 hospitalizations for  
15 prescription opioid overdoses.<sup>37</sup> When emergency visits and hospitalizations  
16 include heroin, the numbers are even higher.<sup>38</sup>

17  
18  
19       <sup>30</sup> Davis, *supra*.

20       <sup>31</sup> Karlamangla, *supra*.

21       <sup>32</sup> California Department of Public Health, *State of California Strategies to Address*  
22 *Prescription Drug (Opioid) Misuse, Abuse, and Overdose Epidemic in California*  
23 at 3 (June 2016), available at  
<https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/CAOpioidPreventionStrategies4.17.pdf> (last visited March 2, 2018).

24       <sup>33</sup> California Department of Public Health, *California Opioid Overdose*  
25 *Surveillance Dashboard*, *supra*.

26       <sup>34</sup> *Id.*

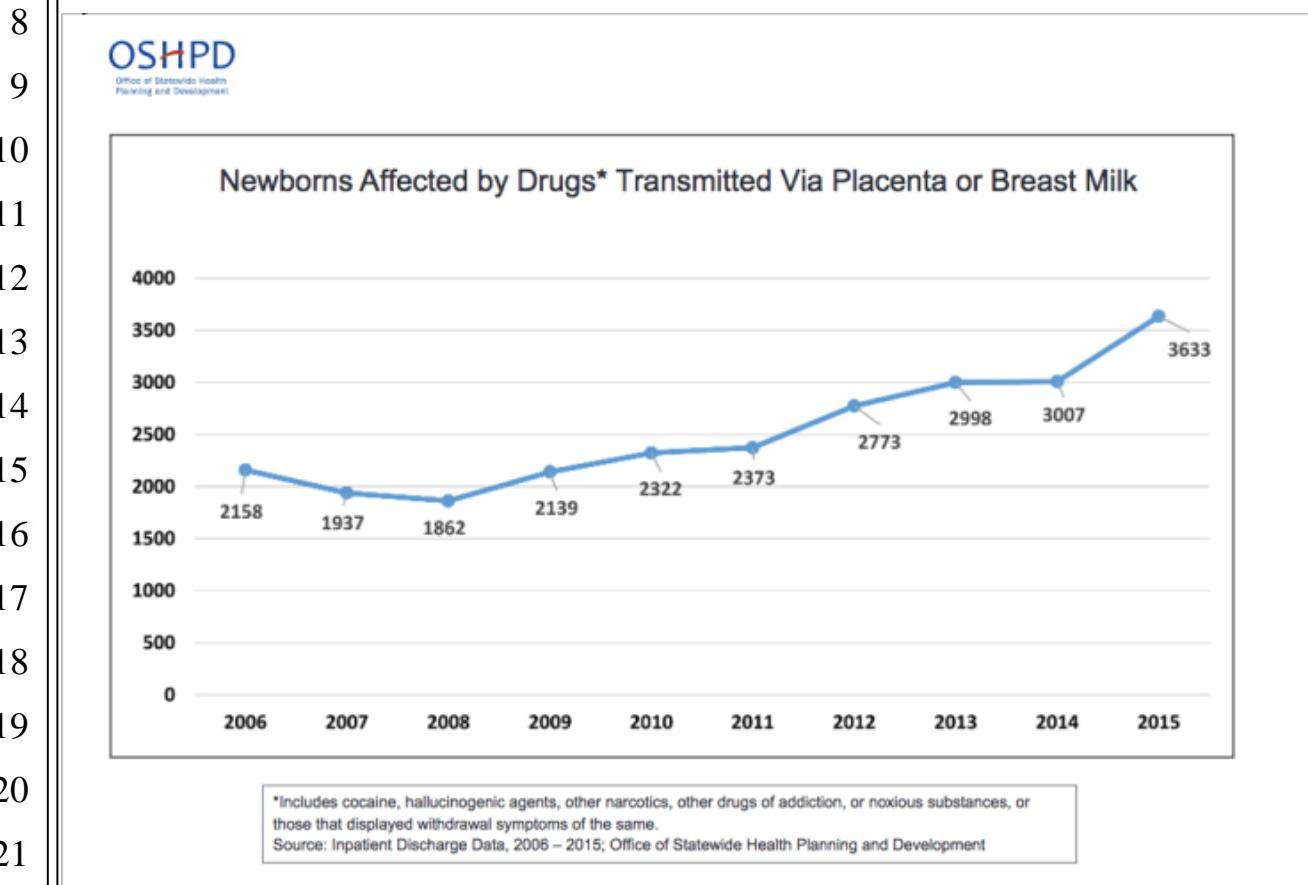
27       <sup>35</sup> *Id.*

28       <sup>36</sup> *Id.*

29       <sup>37</sup> *Id.*

30       <sup>38</sup> *Id.*

1       74. Neonatal Abstinence Syndrome (NAS), a collection of symptoms  
2 newborn babies experience withdrawing from opioid medications taken by the  
3 mother, has increased dramatically in California, with the rate of infants born with  
4 NAS more than tripling from 2008 to 2013.<sup>39</sup> While the number of affected  
5 newborns rose from 1,862 in 2008 to 3,007 in 2014, that number jumped by  
6 another 21 percent in 2015.<sup>40</sup> This is despite a steady decline in the overall  
7 number of birth in California during that same time.<sup>41</sup>



<sup>39</sup> California Child Welfare Co-Investment Partnership, *A Matter of Substance, Challenges and Responses to Parental Substance Use in Child Welfare*, at 5 (Summer 2017), available at [http://www.chhs.ca.gov/Child%20Welfare/CCW\\_Co-Invest\\_Insights\\_DIGITAL\\_FINAL\\_053017.pdf](http://www.chhs.ca.gov/Child%20Welfare/CCW_Co-Invest_Insights_DIGITAL_FINAL_053017.pdf) (last visited March 2, 2018).

<sup>40</sup> Cheryl Clark, "Report Shows Spike in San Diego County Babies Born with Drugs in their Systems," *KPBS* (April 17, 2017), available at <http://www.kpbs.org/news/2017/apr/17/report-shows-spike-san-diego-county-babies-born-dr/> (last visited March 2, 2018).

28 | 41 *Id.*

1       75. Reports from California's Office of Statewide Health Planning,  
 2 which collects data from licensed health care facilities, have shown a 95 percent  
 3 increase between 2008 and 2015 of newborns affected by drugs transmitted via  
 4 placenta or breast milk.<sup>42</sup>

5       76. The opioid epidemic has also had an impact on crime in California.  
 6 Pharmacy robberies have gone up by 163 percent in California over the last two  
 7 years, according to the DEA. The DEA recorded 90 incidents in 2015, 154 in  
 8 2016 and, through mid-November of 2017, that number had climbed to 237.<sup>43</sup>  
 9 Most perpetrators were after prescription opioids.<sup>44</sup> In addition, fentanyl seizures  
 10 at California ports increased 266 percent in fiscal year 2017.<sup>45</sup>

11           **3. The Opioid Epidemic in Plaintiffs' Community.**

12       77. The opioid epidemic is particularly devastating in Plaintiffs'  
 13 Community.

14       78. From 2012 to 2014, the County suffered 27 deaths due to drug  
 15 overdoses, which is a drug overdose mortality rate of 14 deaths per 100,000  
 16 people.<sup>46</sup>

17       79. Prescription opioids have also been responsible for a high rate of  
 18 emergency department visits and hospitalizations in the County. In 2016, Tehama  
 19 County had a rate of 25.2 emergency department visits due to opioid overdoses  
 20

21       <sup>42</sup> California Child Welfare Co-Investment Partnership, *supra*, at 3.

22       <sup>43</sup> Ed Fletcher, "What's behind the spike in drug store robberies?" *The Sacramento Bee*, Dec. 8, 2017 (available at <http://www.sacbee.com/news/local/crime/article188636384.html> (last visited March 2, 2018)).

23       <sup>44</sup> *Id.*

24       <sup>45</sup> United State Department of Justice, The United States Attorney's Office, Southern District of California, *U.S. Attorney Appoints Opioid Coordinators* (Feb. 8, 2018) available at <https://www.justice.gov/usao-sdca/pr/us-attorney-appoints-opioid-coordinators> (last visited March 2, 2018).

25       <sup>46</sup> County Health Rankings & Roadmaps, Drug overdose deaths, available at <http://www.countyhealthrankings.org/app/california/2016/measure/factors/138/data> (last visited April 20, 2018).

1 (excluding heroin), and 26.2 opioid overdose hospitalizations per 100,000  
 2 residents.<sup>47</sup> That hospitalization rate was the third highest in the State that year.<sup>48</sup>

3       80. In 2016, an estimated 5.9 percent of the population aged 12 and up in  
 4 Tehama County misused opioids – that is over 3,200 people in a county of just  
 5 over 63,000 people – and 1.1 percent had an opioid use disorder.<sup>49</sup>

6       81. The CDC has tracked prescription rates per county in the United  
 7 States, identifying the geographic “hotspots” for rates of opioid prescriptions.<sup>50</sup>  
 8 The CDC has calculated the geographic distribution at county levels of opioid  
 9 prescriptions dispensed per 100 persons,<sup>51</sup> revealing that Tehama County has been  
 10 a consistent hotspot over at least the past decade.

11       82. The CDC’s statistics prove that the opioid prescription rates in  
 12 Tehama County have exceeded any legitimate medical, scientific, or industrial  
 13 purpose. The overall opioid prescribing rate in 2016 was 66.5 prescriptions per  
 14 100 people nationally and 44.8 in California.<sup>52</sup> However, in Tehama County,  
 15 California, the 2016 prescription rate was 94.8 per 100 people.<sup>53</sup> This is down  
 16 from the 2015 prescribing rate for Tehama County which was 103.9 per 100  
 17

18       <sup>47</sup> California Department of Public Health, *California Opioid Overdose*  
 19 *Surveillance Dashboard*, available at [https://pdop.shinyapps.io/ODdash\\_v1/](https://pdop.shinyapps.io/ODdash_v1/) (last  
 visited April 27, 2018) (Tehama County specific page).

20       <sup>48</sup> *Id.* at Statewide Table for Opioid Overdose Hospitalizations.

21       <sup>49</sup> Lisa Clemans-Cope, Marni Epstein, and Doug Wissoker, “County-Level  
 22 Estimates of Opioid Use Disorder and Treatment Needs in California,” *The Urban*  
*Institute*, March 19, 2018, available at  
<https://www.urban.org/sites/default/files/Tehama.pdf> (last visited April 27, 2018).

23       <sup>50</sup> U.S. Prescribing Rate Maps, CDC, available at  
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 24 2017).

25       <sup>51</sup> *Id.*

26       <sup>52</sup> *Id. See also* U.S. State Prescribing Rates, 2016, available at  
<https://www.cdc.gov/drugoverdose/maps/rxstate2016.html> (last visited April 18,  
 27 2018).

28       <sup>53</sup> U.S. County Prescribing Rates, 2016, (reporting for “Tehama, CA” here and  
 below) CDC available at  
<https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html> (last visited April 18,  
 2018).

1 people – more than one prescription for every man, woman and child in the  
 2 County.<sup>54</sup>

3       83. Unfortunately, the 2015 and 2016 high rates of opioid prescriptions  
 4 were not an aberration for Tehama County. Consistently, the opioid prescribing  
 5 rates in Tehama County have been significantly greater than the national and state  
 6 averages, well more than one prescription per person living in the County and  
 7 among the highest in the State. Compared to a national average of 75.6 opioid  
 8 prescriptions per 100 people in 2014<sup>55</sup> and 52.7 in California,<sup>56</sup> the Tehama  
 9 County opioid prescription rate was 119.4 per 100 people, almost three times the  
 10 State prescribing rate.<sup>57</sup> In 2013, the national average was 78.1 opioid  
 11 prescriptions per 100 people,<sup>58</sup> but the opioid prescription rate in Tehama County  
 12 was 121.6 per 100 people.<sup>59</sup> Compared to a national average of 81.3 opioid  
 13 prescriptions per 100 people in 2012,<sup>60</sup> the opioid prescription rate in Tehama

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 17 <sup>54</sup> U.S. County Prescribing Rates, 2015, CDC, available at  
 18 <https://www.cdc.gov/drugoverdose/maps/rxcounty2015.html> (last visited April 18,  
 2018).

19 <sup>55</sup> U.S. Prescribing Rate Maps, CDC, available at  
 20 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 2017).

21 <sup>56</sup> U.S. State Prescribing Rates, 2014, CDC, available at  
 22 <https://www.cdc.gov/drugoverdose/maps/rxstate2014.html> (last visited Dec. 11,  
 2017).

23 <sup>57</sup> U.S. County Prescribing Rates, 2014, CDC, available at  
 24 <https://www.cdc.gov/drugoverdose/maps/rxcounty2014.html> (last visited April 18,  
 2018).

25 <sup>58</sup> U.S. Prescribing Rate Maps, CDC, available at  
 26 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 2017).

27 <sup>59</sup> U.S. County Prescribing Rates, 2013, CDC, available at  
 28 <https://www.cdc.gov/drugoverdose/maps/rxcounty2013.html> (last visited April 18,  
 2018).

<sup>60</sup> U.S. Prescribing Rate Maps, CDC, available at  
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 2017).

1 County was 126.9 per 100 people that year.<sup>61</sup> In 2011, the national average was  
 2 80.9 opioid prescriptions per 100 people,<sup>62</sup> but the opioid prescription rate in  
 3 Tehama County was 133.5 per 100 people.<sup>63</sup> Compared to a national average of  
 4 81.2 opioid prescriptions per 100 people in 2010,<sup>64</sup> the Tehama County opioid  
 5 prescription rate was 124.6 per 100 people.<sup>65</sup> In 2009, the national average was  
 6 79.5 opioid prescriptions per 100 people,<sup>66</sup> but the rate in Tehama County was  
 7 125.6 per 100.<sup>67</sup> Compared to a national average of 78.2 opioid prescriptions per  
 8 100 people in 2008<sup>68</sup> and 55.1 in California,<sup>69</sup> the Tehama County rate was 123.6  
 9 per 100 people.<sup>70</sup> In 2007, the national average was 75.9 opioid prescriptions per  
 10  
 11

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12           <sup>61</sup> U.S. County Prescribing Rates, 2012, CDC, available at  
 13           <https://www.cdc.gov/drugoverdose/maps/rxcounty2012.html> (last visited April 18,  
 14           2018).

15           <sup>62</sup> U.S. Prescribing Rate Maps, CDC, available at  
 16           <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 17           2017).

18           <sup>63</sup> U.S. County Prescribing Rates, 2011, CDC, available at  
 19           <https://www.cdc.gov/drugoverdose/maps/rxcounty2011.html> (last visited April 18,  
 20           2018).

21           <sup>64</sup> U.S. Prescribing Rate Maps, CDC, available at  
 22           <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 23           2017).

24           <sup>65</sup> U.S. County Prescribing Rates, 2010, CDC, available at  
 25           <https://www.cdc.gov/drugoverdose/maps/rxcounty2010.html> (last visited April 18,  
 26           2018).

27           <sup>66</sup> U.S. Prescribing Rate Maps, CDC, available at  
 28           <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 29           2017).

30           <sup>67</sup> U.S. County Prescribing Rates, 2009, CDC, available at  
 31           <https://www.cdc.gov/drugoverdose/maps/rxcounty2009.html> (last visited April 18,  
 32           2018).

33           <sup>68</sup> U.S. Prescribing Rate Maps, CDC, available at  
 34           <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 35           2017).

36           <sup>69</sup> U.S. State Prescribing Rates, 2008, CDC, available at  
 37           <https://www.cdc.gov/drugoverdose/maps/rxstate2008.html> (last visited Dec. 11,  
 38           2017).

39           <sup>70</sup> U.S. County Prescribing Rates, 2008, CDC, available at  
 40           <https://www.cdc.gov/drugoverdose/maps/rxcounty2008.html> (last visited April 18,  
 41           2018).

1 100 people,<sup>71</sup> but the Tehama County rate was 121.3 per 100 people.<sup>72</sup> Compared  
2 to a national average of 72.4 opioid prescriptions per 100 people prescribed  
3 opioids in 2006,<sup>73</sup> the Tehama County rate was 109.4 per 100 people.<sup>74</sup>

4 84. The sheer volume of these dangerously addictive drugs was destined  
5 to create the present crisis of addiction, abuse, and overdose deaths.

6 **B. THE MANUFACTURER DEFENDANTS' FALSE, DECEPTIVE,  
7 AND UNFAIR MARKETING OF OPIOIDS.**

8 85. The opioid epidemic did not happen by accident.

9 86. Before the 1990s, generally accepted standards of medical practice  
10 dictated that opioids should only be used short-term for acute pain, pain relating to  
11 recovery from surgery, or for cancer or palliative (end-of-life) care. Due to the  
12 lack of evidence that opioids improved patients' ability to overcome pain and  
13 function, coupled with evidence of greater pain complaints as patients developed  
14 tolerance to opioids over time and the serious risk of addiction and other side  
15 effects, the use of opioids for chronic pain was discouraged or prohibited. As a  
16 result, doctors generally did not prescribe opioids for chronic pain.

17 87. Each Manufacturer Defendant has conducted, and has continued to  
18 conduct, a marketing scheme designed to persuade doctors and patients that  
19 opioids can and should be used for chronic pain, resulting in opioid treatment for a  
20 far broader group of patients who are much more likely to become addicted and  
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22 <sup>71</sup> U.S. Prescribing Rate Maps, CDC, available at  
23 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,,  
2017).

24 <sup>72</sup> U.S. County Prescribing Rates, 2007, CDC, available at  
25 <https://www.cdc.gov/drugoverdose/maps/rxcounty2007.html> (last visited April 18,  
2018).

26 <sup>73</sup> U.S. Prescribing Rate Maps, CDC, available at  
27 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
2017).

28 <sup>74</sup> U.S. County Prescribing Rates, 2006, CDC, available at  
29 <https://www.cdc.gov/drugoverdose/maps/rxcounty2006.html> (last visited April 18,  
2018).

1 suffer other adverse effects from the long-term use of opioids. In connection with  
2 this scheme, each Manufacturer Defendant spent, and continues to spend, millions  
3 of dollars on promotional activities and materials that falsely deny or trivialize the  
4 risks of opioids while overstating the benefits of using them for chronic pain.

5       88. The Manufacturer Defendants have made false and misleading  
6 claims, contrary to the language on their drugs' labels, regarding the risks of using  
7 their drugs that: (1) downplayed the serious risk of addiction; (2) created and  
8 promoted the concept of "pseudoaddiction" when signs of actual addiction began  
9 appearing and advocated that the signs of addiction should be treated with more  
10 opioids; (3) exaggerated the effectiveness of screening tools to prevent addiction;  
11 (4) claimed that opioid dependence and withdrawal are easily managed; (5) denied  
12 the risks of higher opioid dosages; and (6) exaggerated the effectiveness of  
13 "abuse-deterrant" opioid formulations to prevent abuse and addiction. The  
14 Manufacturer Defendants have also falsely touted the benefits of long-term opioid  
15 use, including the supposed ability of opioids to improve function and quality of  
16 life, even though there was no scientifically reliable evidence to support the  
17 Manufacturer Defendants' claims.

18       89. The Manufacturer Defendants have disseminated these common  
19 messages to reverse the popular and medical understanding of opioids and risks of  
20 opioid use. They disseminated these messages directly, through their sales  
21 representatives, in speaker groups led by physicians the Manufacturer Defendants  
22 recruited for their support of their marketing messages, and through unbranded  
23 marketing and industry-funded front groups.

24       90. The Manufacturer Defendants' efforts have been wildly successful.  
25 Opioids are now the most prescribed class of drugs. Globally, opioid sales  
26 generated \$11 billion in revenue for drug companies in 2010 alone; sales in the  
27  
28

United States have exceeded \$8 billion in revenue annually since 2009.<sup>75</sup> In an open letter to the nation’s physicians in August 2016, the then-U.S. Surgeon General expressly connected this “urgent health crisis” to “heavy marketing of opioids to doctors . . . [m]any of [whom] were even taught – incorrectly – that opioids are not addictive when prescribed for legitimate pain.”<sup>76</sup> This epidemic has resulted in a flood of prescription opioids available for illicit use or sale (the supply), and a population of patients physically and psychologically dependent on them (the demand). And when those patients can no longer afford or obtain opioids from licensed dispensaries, they often turn to the street to buy prescription opioids or even non-prescription opioids, like heroin.

91. The Manufacturer Defendants intentionally continued their conduct, as alleged herein, with knowledge that such conduct was creating the opioid nuisance and causing the harms and damages alleged herein.

**1. Each Manufacturer Defendant Used Multiple Avenues to Disseminate Their False and Deceptive Statements about Opioids.**

92. The Manufacturer Defendants spread their false and deceptive statements by marketing their branded opioids directly to doctors and patients in and around the State, including in Plaintiffs’ Community. Defendants also deployed seemingly unbiased and independent third parties that they controlled to spread their false and deceptive statements about the risks and benefits of opioids for the treatment of chronic pain throughout the State and Plaintiffs’ Community.

93. The Manufacturer Defendants employed the same marketing plans and strategies and deployed the same messages in and around the State, including

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<sup>75</sup> See Katherine Eban, *Oxycontin: Purdue Pharma’s Painful Medicine*, Fortune, Nov. 9, 2011, <http://fortune.com/2011/11/09/oxycontin-purdue-pharma-painful-medicine/>; David Crow, *Drugmakers Hooked on \$10bn Opioid Habit*, Fin. Times, Aug. 10, 2016, <https://www.ft.com/content/f6e989a8-5dac-11e6-bb77-a121aa8abd95>.

<sup>76</sup> Letter from Vivek H. Murthy, U.S. Surgeon General (Aug. 2016), <http://turnthetiderx.org/>.

1 in Plaintiffs' Community, as they did nationwide. Across the pharmaceutical  
2 industry, "core message" development is funded and overseen on a national basis  
3 by corporate headquarters. This comprehensive approach ensures that the  
4 Manufacturer Defendants' messages are accurately and consistently delivered  
5 across marketing channels – including detailing visits, speaker events, and  
6 advertising – and in each sales territory. The Manufacturer Defendants consider  
7 this high level of coordination and uniformity crucial to successfully marketing  
8 their drugs.

9       94. The Manufacturer Defendants ensure marketing consistency  
10 nationwide through national and regional sales representative training; national  
11 training of local medical liaisons, the company employees who respond to  
12 physician inquiries; centralized speaker training; single sets of visual aids, speaker  
13 slide decks and sales training materials; and nationally coordinated advertising.  
14 The Manufacturer Defendants' sales representatives and physician speakers were  
15 required to stick to prescribed talking points, sales messages, and slide decks, and  
16 supervisors rode along with them periodically to both check on their performance  
17 and compliance.

18                   **a) Direct Marketing.**

19       95. The Manufacturer Defendants' direct marketing of opioids generally  
20 proceeded on two tracks. First, each Manufacturer Defendant conducted and  
21 continues to conduct advertising campaigns touting the purported benefits of their  
22 branded drugs. For example, upon information and belief, the Manufacturer  
23 Defendants spent more than \$14 million on medical journal advertising of opioids  
24 in 2011, nearly triple what they spent in 2001.

25       96. Many of the Manufacturer Defendants' branded ads deceptively  
26 portrayed the benefits of opioids for chronic pain. For example, Endo distributed  
27 and made available on its website opana.com a pamphlet promoting Opana ER  
28 with photographs depicting patients with physically demanding jobs like

1 construction worker, chef, and teacher, misleadingly implying that the drug would  
2 provide long-term pain-relief and functional improvement. Upon information and  
3 belief, Purdue also ran a series of ads, called “Pain vignettes,” for OxyContin in  
4 2012 in medical journals. These ads featured chronic pain patients and  
5 recommended OxyContin for each. One ad described a “54-year-old writer with  
6 osteoarthritis of the hands” and implied that OxyContin would help the writer  
7 work more effectively.

8       97. Second, each Manufacturer Defendant promoted the use of opioids  
9 for chronic pain through “detailers” – sales representatives who visited individual  
10 doctors and medical staff in their offices – and small-group speaker programs. The  
11 Manufacturer Defendants have not corrected this misinformation. Instead, each  
12 Defendant devoted massive resources to direct sales contacts with doctors. Upon  
13 information and belief, in 2014 alone, the Manufacturer Defendants spent in  
14 excess of \$168 million on detailing branded opioids to doctors, more than twice  
15 what they spent on detailing in 2000.

16       98. The Manufacturer Defendants’ detailing to doctors is effective.  
17 Numerous studies indicate that marketing impacts prescribing habits, with face-to-  
18 face detailing having the greatest influence. Even without such studies, the  
19 Manufacturer Defendants purchase, manipulate and analyze some of the most  
20 sophisticated data available in any industry, data available from IMS Health  
21 Holdings, Inc., to track, precisely, the rates of initial prescribing and renewal by  
22 individual doctor, which in turn allows them to target, tailor, and monitor the  
23 impact of their core messages. Thus, the Manufacturer Defendants know their  
24 detailing to doctors is effective.

25       99. The Manufacturer Defendants’ detailers have been reprimanded for  
26 their deceptive promotions. In March 2010, for example, the FDA found that  
27 Actavis had been distributing promotional materials that “minimize[] the risks  
28 associated with Kadian and misleadingly suggest[] that Kadian is safer than has

1 been demonstrated.” Those materials in particular “fail to reveal warnings  
 2 regarding potentially fatal abuse of opioids, use by individuals other than the  
 3 patient for whom the drug was prescribed.”<sup>77</sup>

4                   **b) Indirect Marketing.**

5                 100. The Manufacturer Defendants indirectly marketed their opioids using  
 6 unbranded advertising, paid speakers and “key opinion leaders” (“KOLs”), and  
 7 industry-funded organizations posing as neutral and credible professional societies  
 8 and patient advocacy groups (referred to hereinafter as “Front Groups”).

9                 101. The Manufacturer Defendants deceptively marketed opioids in the  
 10 State and Plaintiffs’ Community through unbranded advertising – e.g., advertising  
 11 that promotes opioid use generally but does not name a specific opioid. This  
 12 advertising was ostensibly created and disseminated by independent third parties.  
 13 But by funding, directing, reviewing, editing, and distributing this unbranded  
 14 advertising, the Manufacturer Defendants controlled the deceptive messages  
 15 disseminated by these third parties and acted in concert with them to falsely and  
 16 misleadingly promote opioids for the treatment of chronic pain. Much as  
 17 Defendants controlled the distribution of their “core messages” via their own  
 18 detailers and speaker programs, the Manufacturer Defendants similarly controlled  
 19 the distribution of these messages in scientific publications, treatment guidelines,  
 20 Continuing Medical Education (“CME”) programs, and medical conferences and  
 21 seminars. To this end, the Manufacturer Defendants used third-party public  
 22 relations firms to help control those messages when they originated from third-  
 23 parties.

24                 102. The Manufacturer Defendants marketed through third-party,  
 25 unbranded advertising to avoid regulatory scrutiny because that advertising is not

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27                 28                 <sup>77</sup> Letter from Thomas Abrams, Dir., Div. of Drug Mktg., Advert., & Commc’ns,  
 U.S. Food & Drug Admin., to Doug Boothe, CEO, Actavis Elizabeth LLC (Feb.  
 18, 2010),  
<http://www.fdanews.com/ext/resources/files/archives/a/ActavisElizabethLLC.pdf>.

1 submitted to and typically is not reviewed by the FDA. The Manufacturer  
2 Defendants also used third-party, unbranded advertising to give the false  
3 appearance that the deceptive messages came from an independent and objective  
4 source. Like the tobacco companies, the Manufacturer Defendants used third  
5 parties that they funded, directed, and controlled to carry out and conceal their  
6 scheme to deceive doctors and patients about the risks and benefits of long term  
7 opioid use for chronic pain.

8       103. Defendants also identified doctors to serve, for payment, on their  
9 speakers' bureaus and to attend programs with speakers and meals paid for by  
10 Defendants. These speaker programs provided: (1) an incentive for doctors to  
11 prescribe a particular opioid (so they might be selected to promote the drug); (2)  
12 recognition and compensation for the doctors selected as speakers; and (3) an  
13 opportunity to promote the drug through the speaker to his or her peers. These  
14 speakers give the false impression that they are providing unbiased and medically  
15 accurate presentations when they are, in fact, presenting a script prepared by  
16 Defendants. On information and belief, these presentations conveyed misleading  
17 information, omitted material information, and failed to correct Defendants' prior  
18 misrepresentations about the risks and benefits of opioids.

19       104. Borrowing a page from Big Tobacco's playbook, the Manufacturer  
20 Defendants worked through third parties they controlled by: (a) funding, assisting,  
21 encouraging, and directing doctors who served as KOLS, and (b) funding,  
22 assisting, directing, and encouraging seemingly neutral and credible Front Groups.  
23 The Manufacturer Defendants then worked together with those KOLs and Front  
24 Groups to taint the sources that doctors and patients relied on for ostensibly  
25 "neutral" guidance, such as treatment guidelines, CME programs, medical  
26 conferences and seminars, and scientific articles. Thus, working individually and  
27 collectively, and through these Front Groups and KOLs, the Manufacturer  
28 Defendants persuaded doctors and patients that what they have long known – that

1       opioids are addictive drugs, unsafe in most circumstances for long-term use – was  
2       untrue, and that the compassionate treatment of pain required opioids.

3           105. In 2007, multiple States sued Purdue for engaging in unfair and  
4       deceptive practices in its marketing, promotion, and sale of OxyContin. Certain  
5       states settled their claims in a series of Consent Judgments that prohibited Purdue  
6       from making misrepresentations in the promotion and marketing of OxyContin in  
7       the future. By using indirect marketing strategies, however, Purdue intentionally  
8       circumvented these restrictions. Such actions include contributing to the creation  
9       of misleading publications and prescribing guidelines which lack reliable  
10      scientific basis, and promoting prescribing practices which have worsened the  
11      opioid crisis.

12           106. Pro-opioid doctors are one of the most important avenues that the  
13       Manufacturer Defendants use to spread their false and deceptive statements about  
14       the risks and benefits of long-term opioid use. The Manufacturer Defendants  
15       know that doctors rely heavily and less critically on their peers for guidance, and  
16       KOLs provide the false appearance of unbiased and reliable support for chronic  
17       opioid therapy. For example, the State of New York found in its settlement with  
18       Purdue that the Purdue website “In the Face of Pain” failed to disclose that doctors  
19       who provided testimonials on the site were paid by Purdue and concluded that  
20       Purdue’s failure to disclose these financial connections potentially misled  
21       consumers regarding the objectivity of the testimonials.

22           107. Defendants utilized many KOLs, including many of the same ones.

23           108. Dr. Russell Portenoy, former Chairman of the Department of Pain  
24       Medicine and Palliative Care at Beth Israel Medical Center in New York, is one  
25       example of a KOL whom the Manufacturer Defendants identified and promoted to  
26       further their marketing campaign. Dr. Portenoy received research support,  
27       consulting fees, and honoraria from Cephalon, Endo, Janssen, and Purdue (among  
28       others), and was a paid consultant to Cephalon and Purdue. Dr. Portenoy was

1 instrumental in opening the door for the regular use of opioids to treat chronic  
2 pain. He served on the American Pain Society (“APS”) / American Academy of  
3 Pain Medicine (“AAPM”) Guidelines Committees, which endorsed the use of  
4 opioids to treat chronic pain, first in 1996 and again in 2009. He was also a  
5 member of the board of the American Pain Foundation (“APF”), an advocacy  
6 organization almost entirely funded by the Manufacturer Defendants.

7       109. Dr. Portenoy also made frequent media appearances promoting  
8       opioids and spreading misrepresentations, such as his claim that “the likelihood  
9       that the treatment of pain using an opioid drug which is prescribed by a doctor  
10      will lead to addiction is extremely low.” He appeared on Good Morning America  
11      in 2010 to discuss the use of opioids long-term to treat chronic pain. On this  
12      widely-watched program, broadcast across the country, Dr. Portenoy claimed:  
13      “Addiction, when treating pain, is distinctly uncommon. If a person does not have  
14      a history, a personal history, of substance abuse, and does not have a history in the  
15      family of substance abuse, and does not have a very major psychiatric disorder,  
16      most doctors can feel very assured that that person is not going to become  
17      addicted.”<sup>78</sup>

18        110. Dr. Portenoy later admitted that he “gave innumerable lectures in the  
19 late 1980s and ‘90s about addiction that weren’t true.” These lectures falsely  
20 claimed that fewer than 1% of patients would become addicted to opioids.  
21 According to Dr. Portenoy, because the primary goal was to “destigmatize”  
22 opioids, he and other doctors promoting them overstated their benefits and glossed  
23 over their risks. Dr. Portenoy also conceded that “[d]ata about the effectiveness of  
24 opioids does not exist.”<sup>79</sup> Portenoy candidly stated: “Did I teach about pain

<sup>26</sup> <sup>78</sup> Good Morning America (ABC television broadcast Aug. 30, 2010).

<sup>79</sup> Thomas Catan & Evan Perez, *A Pain-Drug Champion Has Second Thoughts*, Wall St. J., Dec. 17, 2012, <https://www.wsj.com/articles/SB10001424127887324478304578173342657044604>.

1 management, specifically about opioid therapy, in a way that reflects  
2 misinformation? Well, . . . I guess I did.”<sup>80</sup>

3       111. Another KOL, Dr. Lynn Webster, was the co-founder and Chief  
4 Medical Director of Lifetree Clinical Research, an otherwise unknown pain clinic  
5 in Salt Lake City, Utah. Dr. Webster was President of the AAPM in 2013. He is a  
6 Senior Editor of Pain Medicine, the same journal that published Endo special  
7 advertising supplements touting Opana ER. Dr. Webster was the author of  
8 numerous CMEs sponsored by Cephalon, Endo, and Purdue. At the same time,  
9 Dr. Webster was receiving significant funding from the Manufacturer Defendants  
10 (including nearly \$2 million from Cephalon).

11       112. During a portion of his time as a KOL, Dr. Webster was under  
12 investigation for overprescribing by the U.S. Department of Justice’s Drug  
13 Enforcement Agency, which raided his clinic in 2010. Although the investigation  
14 was closed without charges in 2014, more than 20 of Dr. Webster’s former  
15 patients at the Lifetree Clinic have died of opioid overdoses.

16       113. Ironically, Dr. Webster created and promoted the Opioid Risk Tool, a  
17 five question, one-minute screening tool relying on patient self-reports that  
18 purportedly allows doctors to manage the risk that their patients will become  
19 addicted to or abuse opioids. The claimed ability to pre-sort patients likely to  
20 become addicted is an important tool in giving doctors confidence to prescribe  
21 opioids long-term, and for this reason, references to screening appear in various  
22 industry-supported guidelines. Versions of Dr. Webster’s Opioid Risk Tool appear  
23 on, or are linked to, websites run by Endo, Janssen, and Purdue. Unaware of the  
24 flawed science and industry bias underlying this tool, certain states and public  
25 entities have incorporated the Opioid Risk Tool into their own guidelines,

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<sup>80</sup> *Id.*

1 indicating, also, their reliance on the Manufacturer Defendants and those under  
 2 their influence and control.

3       114. In 2011, Dr. Webster presented, via webinar, a program sponsored by  
 4 Purdue entitled “Managing Patient’s Opioid Use: Balancing the Need and the  
 5 Risk.” Dr. Webster recommended use of risk screening tools, urine testing, and  
 6 patient agreements as a way to prevent “overuse of prescriptions” and “overdose  
 7 deaths.” This webinar was available to and was intended to reach doctors in the  
 8 State and doctors treating members of Plaintiffs’ Community.<sup>81</sup>

9       115. Dr. Webster also was a leading proponent of the concept of  
 10 “pseudoaddiction,” the notion that addictive behaviors should be seen not as  
 11 warnings, but as indications of undertreated pain. In Dr. Webster’s description, the  
 12 only way to differentiate the two was to increase a patient’s dose of opioids. As he  
 13 and co-author Beth Dove wrote in their 2007 book *Avoiding Opioid Abuse While*  
 14 *Managing Pain*—a book that is still available online—when faced with signs of  
 15 aberrant behavior, increasing the dose “in most cases . . . should be the clinician’s  
 16 first response.”<sup>82</sup> Upon information and belief, Endo distributed this book to  
 17 doctors. Years later, Dr. Webster reversed himself, acknowledging that  
 18 “[pseudoaddiction] obviously became too much of an excuse to give patients more  
 19 medication.”<sup>83</sup>

20       116. The Manufacturer Defendants also entered into arrangements with  
 21 seemingly unbiased and independent patient and professional organizations to  
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23       <sup>81</sup> See Emerging Solutions in Pain, *Managing Patient’s Opioid Use: Balancing the*  
 24 *Need and the Risk*, [http://www.emergingsolutionsinpain.com/ce-education/opioid-management?option=com\\_continued&view=frontmatter&Itemid=303&course=209](http://www.emergingsolutionsinpain.com/ce-education/opioid-management?option=com_continued&view=frontmatter&Itemid=303&course=209) (last visited Aug. 22, 2017).

25       <sup>82</sup> Lynn Webster & Beth Dove, *Avoiding Opioid Abuse While Managing Pain* (2007).

26       <sup>83</sup> John Fauber, *Painkiller Boom Fueled by Networking*, Milwaukee Wisc. J. Sentinel, Feb. 18, 2012, <http://archive.jsonline.com/watchdog/watchdogreports/painkiller-boom-fueled-by-networking-dp3p2rn-139609053.html>.

1 promote opioids for the treatment of chronic pain. Under the direction and control  
 2 of the Manufacturer Defendants, these “Front Groups” generated treatment  
 3 guidelines, unbranded materials, and programs that favored chronic opioid  
 4 therapy. They also assisted the Manufacturer Defendants by responding to  
 5 negative articles, by advocating against regulatory changes that would limit opioid  
 6 prescribing in accordance with the scientific evidence, and by conducting outreach  
 7 to vulnerable patient populations targeted by the Manufacturer Defendants.

8       117. These Front Groups depended on the Manufacturer Defendants for  
 9 funding and, in some cases, for survival. The Manufacturer Defendants also  
 10 exercised control over programs and materials created by these groups by  
 11 collaborating on, editing, and approving their content, and by funding their  
 12 dissemination. In doing so, the Manufacturer Defendants made sure that the Front  
 13 Groups would generate only the messages that the Manufacturer Defendants  
 14 wanted to distribute. Despite this, the Front Groups held themselves out as  
 15 independent and serving the needs of their members – whether patients suffering  
 16 from pain or doctors treating those patients.

17       118. Defendants Cephalon, Endo, Janssen, and Purdue, in particular,  
 18 utilized many Front Groups, including many of the same ones. Several of the most  
 19 prominent are described below, but there are many others, including the American  
 20 Pain Society (“APS”), American Geriatrics Society (“AGS”), the Federation of  
 21 State Medical Boards (“FSMB”), American Chronic Pain Association (“ACPA”),  
 22 the Center for Practical Bioethics (“CPB”), the U.S. Pain Foundation (“USPF”)  
 23 and Pain & Policy Studies Group (“PPSG”).<sup>84</sup>

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 26       84 See generally, e.g., Letter from Sen. Ron Wyden, U.S. Senate Comm. on Fin., to  
 27 Sec. Thomas E. Price, U.S. Dep’t of Health and Human Servs., (May 5, 2015),  
<https://www.finance.senate.gov/imo/media/doc/050517%20Senator%20Wyden%20to%20Secretary%20Price%20re%20FDA%20Opioid%20Prescriber%20Working%20Group.pdf>.

1       119. The most prominent of the Manufacturer Defendants' Front Groups  
2 was the American Pain Foundation ("APF"), which, upon information and belief,  
3 received more than \$10 million in funding from opioid manufacturers from 2007  
4 until it closed its doors in May 2012, primarily from Endo and Purdue. APF  
5 issued education guides for patients, reporters, and policymakers that touted the  
6 benefits of opioids for chronic pain and trivialized their risks, particularly the risk  
7 of addiction. APF also launched a campaign to promote opioids for returning  
8 veterans, which has contributed to high rates of addiction and other adverse  
9 outcomes – including death – among returning soldiers. APF also engaged in a  
10 significant multimedia campaign – through radio, television and the internet – to  
11 educate patients about their "right" to pain treatment, namely opioids. All of the  
12 programs and materials were available nationally and were intended to reach  
13 citizens of the State and Plaintiffs' Community.

14       120. In 2009 and 2010, more than 80% of APF's operating budget came  
15 from pharmaceutical industry sources. Including industry grants for specific  
16 projects, APF received about \$2.3 million from industry sources out of total  
17 income of about \$2.85 million in 2009; its budget for 2010 projected receipts of  
18 roughly \$2.9 million from drug companies, out of total income of about \$3.5  
19 million. By 2011, upon information and belief, APF was entirely dependent on  
20 incoming grants from defendants Purdue, Cephalon, Endo, and others to avoid  
21 using its line of credit.

22       121. APF held itself out as an independent patient advocacy organization.  
23 It often engaged in grassroots lobbying against various legislative initiatives that  
24 might limit opioid prescribing, and thus the profitability of its sponsors. Upon  
25 information and belief, it was often called upon to provide "patient  
26 representatives" for the Manufacturer Defendants' promotional activities,  
27 including for Purdue's Partners Against Pain and Janssen's Let's Talk Pain. APF  
28 functioned largely as an advocate for the interests of the Manufacturer

1 Defendants, not patients. Indeed, upon information and belief, as early as 2001,  
2 Purdue told APF that the basis of a grant was Purdue’s desire to “strategically  
3 align its investments in nonprofit organizations that share [its] business interests.”

4       122. Plaintiffs are informed and believe that on several occasions,  
5 representatives of the Manufacturer Defendants, often at informal meetings at  
6 conferences, suggested activities and publications for APF to pursue. APF then  
7 submitted grant proposals seeking to fund these activities and publications,  
8 knowing that drug companies would support projects conceived as a result of  
9 these communications.

10      123. The U.S. Senate Finance Committee began looking into APF in May  
11 2012 to determine the links, financial and otherwise, between the organization and  
12 the manufacturers of opioid painkillers. The investigation caused considerable  
13 damage to APF’s credibility as an objective and neutral third party, and the  
14 Manufacturer Defendants stopped funding it. Within days of being targeted by  
15 Senate investigation, APF’s board voted to dissolve the organization “due to  
16 irreparable economic circumstances.” APF “cease[d] to exist, effective  
17 immediately.”<sup>85</sup>

18      124. Another front group for the Manufacturer Defendants was the  
19 American Academy of Pain Medicine (“AAPM”). With the assistance, prompting,  
20 involvement, and funding of the Manufacturer Defendants, the AAPM issued  
21 purported treatment guidelines and sponsored and hosted medical education  
22 programs essential to the Manufacturer Defendants’ deceptive marketing of  
23 chronic opioid therapy.

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27      <sup>85</sup> Charles Ornstein & Tracy Weber, *Senate Panel Investigates Drug Companies’ Ties to Pain Groups*, Wash. Post, May 8, 2012, [https://www.washingtonpost.com/national/health-science/senate-panel-investigates-drug-companies-ties-to-pain-groups/2012/05/08/gIQA2X4qBU\\_story.html](https://www.washingtonpost.com/national/health-science/senate-panel-investigates-drug-companies-ties-to-pain-groups/2012/05/08/gIQA2X4qBU_story.html).

1       125. AAPM received substantial funding from opioid manufacturers. For  
2 example, AAPM maintained a corporate relations council, whose members paid  
3 \$25,000 per year (on top of other funding) to participate. The benefits included  
4 allowing members to present educational programs at off-site dinner symposia in  
5 connection with AAPM's marquee event – its annual meeting held in Palm  
6 Springs, California, or other resort locations. AAPM describes the annual event as  
7 an “exclusive venue” for offering education programs to doctors. Membership in  
8 the corporate relations council also allows drug company executives and  
9 marketing staff to meet with AAPM executive committee members in small  
10 settings. Defendants Endo, Purdue, and Cephalon were members of the council  
11 and presented deceptive programs to doctors who attended this annual event.

12       126. Upon information and belief, AAPM is viewed internally by Endo as  
13 “industry friendly,” with Endo advisors and speakers among its active members.  
14 Endo attended AAPM conferences, funded its CMEs, and distributed its  
15 publications. The conferences sponsored by AAPM heavily emphasized sessions  
16 on opioids – 37 out of roughly 40 at one conference alone. AAPM’s presidents  
17 have included top industry-supported KOLs Perry Fine and Lynn Webster. Dr.  
18 Webster was even elected president of AAPM while under a DEA investigation.

19       127. The Manufacturer Defendants were able to influence AAPM through  
20 both their significant and regular funding and the leadership of pro-opioid KOLs  
21 within the organization.

22       128. In 1996, AAPM and APS jointly issued a consensus statement, “The  
23 Use of Opioids for the Treatment of Chronic Pain,” which endorsed opioids to  
24 treat chronic pain and claimed that the risk of a patients’ addiction to opioids was  
25 low. Dr. Haddox, who co-authored the AAPM/APS statement, was a paid speaker  
26 for Purdue at the time. Dr. Portenoy was the sole consultant. The consensus  
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28

1 statement remained on AAPM's website until 2011, and, upon information and  
 2 belief, was taken down from AAPM's website only after a doctor complained.<sup>86</sup>

3       129. AAPM and APS issued their own guidelines in 2009 ("AAPM/APS  
 4 Guidelines") and continued to recommend the use of opioids to treat chronic  
 5 pain.<sup>87</sup> Treatment guidelines have been relied upon by doctors, especially the  
 6 general practitioners and family doctors targeted by the Manufacturer Defendants.  
 7 Treatment guidelines not only directly inform doctors' prescribing practices, but  
 8 are cited throughout the scientific literature and referenced by third-party payors  
 9 in determining whether they should cover treatments for specific indications.  
 10 Pharmaceutical sales representatives employed by Endo, Actavis, and Purdue  
 11 discussed treatment guidelines with doctors during individual sales visits.

12       130. At least fourteen of the 21 panel members who drafted the  
 13 AAPM/APS Guidelines, including KOLs Dr. Portenoy and Dr. Perry Fine of the  
 14 University of Utah, received support from Janssen, Cephalon, Endo, and Purdue.  
 15 The 2009 Guidelines promote opioids as "safe and effective" for treating chronic  
 16 pain, despite acknowledging limited evidence, and conclude that the risk of  
 17 addiction is manageable for patients regardless of past abuse histories.<sup>88</sup> One  
 18 panel member, Dr. Joel Saper, Clinical Professor of Neurology at Michigan State  
 19 University and founder of the Michigan Headache & Neurological Institute,  
 20 resigned from the panel because of his concerns that the 2009 Guidelines were  
 21 influenced by contributions that drug companies, including Manufacturer  
 22 Defendants, made to the sponsoring organizations and committee members. These  
 23 AAPM/APS Guidelines have been a particularly effective channel of deception

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 25       <sup>86</sup> The Use of Opioids for the Treatment of Chronic Pain: A Consensus Statement  
 26 From the American Academy of Pain Medicine and the American Pain Society, 13  
 27 Clinical J. Pain 6 (1997).

28       <sup>87</sup> Roger Chou et al., Clinical Guidelines for the Use of Chronic Opioid Therapy in  
 29 Chronic Non-Cancer Pain, 10 J. Pain 113 (2009).

<sup>88</sup> *Id.*

1 and have influenced not only treating physicians, but also the body of scientific  
 2 evidence on opioids; the Guidelines have been cited hundreds of times in  
 3 academic literature, were disseminated in the State and/or Plaintiffs' Community  
 4 during the relevant time period, are still available online, and were reprinted in the  
 5 Journal of Pain. The Manufacturer Defendants widely referenced and promoted  
 6 the 2009 Guidelines without disclosing the lack of evidence to support them or the  
 7 Manufacturer Defendants' financial support to members of the panel.

8       131. The Manufacturer Defendants worked together, through Front  
 9 Groups, to spread their deceptive messages about the risks and benefits of long-  
 10 term opioid therapy. For example, Defendants combined their efforts through the  
 11 Pain Care Forum ("PCF"), which began in 2004 as an APF project. PCF is  
 12 comprised of representatives from opioid manufacturers (including Cephalon,  
 13 Endo, Janssen, and Purdue) and various Front Groups, almost all of which  
 14 received substantial funding from the Manufacturer Defendants. Among other  
 15 projects, PCF worked to ensure that an FDA-mandated education project on  
 16 opioids was not unacceptably negative and did not require mandatory participation  
 17 by prescribers, which the Manufacturer Defendants determined would reduce  
 18 prescribing.

19           **2. The Manufacturer Defendants' Marketing Scheme**  
 20           **Misrepresented the Risks and Benefits of Opioids.**

21           **i. The Manufacturer Defendants embarked upon a campaign**  
 22           **of false, deceptive, and unfair assurances grossly**  
 23           **understating and misstating the dangerous addiction risks**  
 24           **of the opioid drugs.**

25       132. To falsely assure physicians and patients that opioids are safe, the  
 26 Manufacturer Defendants deceptively trivialized and failed to disclose the risks of  
 27 long-term opioid use, particularly the risk of addiction, through a series of  
 28 misrepresentations that have been conclusively debunked by the FDA and CDC.  
 These misrepresentations – which are described below – reinforced each other and  
 created the dangerously misleading impression that: (1) starting patients on

1       opioids was low risk because most patients would not become addicted, and  
 2       because those at greatest risk for addiction could be identified and managed; (2)  
 3       patients who displayed signs of addiction probably were not addicted and, in any  
 4       event, could easily be weaned from the drugs; (3) the use of higher opioid doses,  
 5       which many patients need to sustain pain relief as they develop tolerance to the  
 6       drugs, do not pose special risks; and (4) abuse-deterrent opioids both prevent  
 7       abuse and overdose and are inherently less addictive. The Manufacturer  
 8       Defendants have not only failed to correct these misrepresentations, they continue  
 9       to make them today.

10       133. Opioid manufacturers, including Defendants Endo Pharmaceuticals,  
 11       Inc. and Purdue Pharma L.P., have entered into settlement agreements with public  
 12       entities that prohibit them from making many of the misrepresentations identified  
 13       in this Complaint. Yet even afterward, each Manufacturer Defendant continued to  
 14       misrepresent the risks and benefits of long-term opioid use in the State and  
 15       Plaintiffs' Community and each continues to fail to correct its past  
 16       misrepresentations.

17       134. Some illustrative examples of the Manufacturer Defendants' false,  
 18       deceptive, and unfair claims about the purportedly low risk of addiction include:

- 19           a. Actavis's predecessor caused a patient education brochure, *Managing*  
           20       *Chronic Back Pain*, to be distributed beginning in 2003 that admitted  
           21       that opioid addiction is possible, but falsely claimed that it is "less  
           22       likely if you have never had an addiction problem." Based on  
           23       Actavis's acquisition of its predecessor's marketing materials along  
           24       with the rights to Kadian, it appears that Actavis continued to use this  
           25       brochure in 2009 and beyond.
- 26           b. Cephalon and Purdue sponsored APF's *Treatment Options: A Guide*  
           27       *for People Living with Pain* (2007), which suggested that addiction is  
           28       rare and limited to extreme cases of unauthorized dose escalations,  
           29       obtaining duplicative opioid prescriptions from multiple sources, or  
           30       theft. This publication is still available online.<sup>89</sup>

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27       <sup>89</sup> Am. Pain Found., *Treatment Options: A Guide for People Living in Pain* (2007)  
 28       [hereinafter APF, *Treatment Options*],  
 https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf.

- c. Endo sponsored a website, “PainKnowledge,” which, upon information and belief, claimed in 2009 that “[p]eople who take opioids as prescribed usually do not become addicted.” Upon information and belief, another Endo website, PainAction.com, stated “Did you know? Most chronic pain patients do not become addicted to the opioid medications that are prescribed for them.” Endo also distributed an “Informed Consent” document on PainAction.com that misleadingly suggested that only people who “have problems with substance abuse and addiction” are likely to become addicted to opioid medications.
- d. Upon information and belief, Endo distributed a pamphlet with the Endo logo entitled *Living with Someone with Chronic Pain*, which stated that: “Most health care providers who treat people with pain agree that most people do not develop an addiction problem.”
- e. Janssen reviewed, edited, approved, and distributed a patient education guide entitled *Finding Relief: Pain Management for Older Adults* (2009), which described as “myth” the claim that opioids are addictive, and asserted as fact that “[m]any studies show that opioids are rarely addictive when used properly for the management of chronic pain.”
- f. Janssen currently runs a website, Prescriberesponsibly.com (last updated July 2, 2015), which claims that concerns about opioid addiction are “overestimated.”
- g. Purdue sponsored APF’s *A Policymaker’s Guide to Understanding Pain & Its Management*, which claims that less than 1% of children prescribed opioids will become addicted and that pain is undertreated due to “[m]isconceptions about opioid addiction.”<sup>90</sup>
- h. In 2010, Mallinckrodt sponsored an initiative “Collaborating and Acting Responsibly to Ensure Safety (C.A.R.E.S.), through which it published and promoted the book “Defeat Chronic Pain Now!” aimed at chronic pain patients. The book, which is still available for sale in New Mexico and elsewhere, and is promoted online at [www.defeatchronicpainnow.com](http://www.defeatchronicpainnow.com), advises laypeople who are considering taking opioid drugs that “[o]nly rarely does opioid medication cause a true addiction.”<sup>91</sup> Further, the book advises that even the issue of tolerance is “overblown,” because “[o]nly a minority of chronic pain patients who are taking long-term opioids develop tolerance.” In response to a hypothetical question from a chronic back pain patient who expresses a fear of becoming addicted, the book advises that “[i]t is very uncommon for a person with chronic pain to become ‘addicted’ to narcotics IF (1) he doesn’t have a prior history of any addiction and (2) he only takes the medication to treat pain.”

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<sup>90</sup> Am. Pain Found., *A Policymaker’s Guide to Understanding Pain and Its Management* 6 (2011) [hereinafter APF, *Policymaker’s Guide*], <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf>.

<sup>91</sup> Charles E. Argoff & Bradley S. Galer, *Defeat Chronic Pain Now!* (2010).

- 1           i. Consistent with the Manufacturer Defendants' published marketing
- 2           materials, upon information and belief, detailers for Purdue, Endo,
- 3           Janssen, and Cephalon in the State and Plaintiffs' Community
- 4           minimized or omitted any discussion with doctors of the risk of
- 5           addiction; misrepresented the potential for abuse of opioids with
- 6           purportedly abuse-deterrent formulations; and routinely did not
- 7           correct the misrepresentations noted above.
- 8           j. Seeking to overturn the criminal conviction of a doctor for illegally
- 9           prescribing opioids, the Manufacturer Defendants' Front Groups APF
- 10          and NFP argued in an *amicus* brief to the United States Fourth
- 11          Circuit Court of Appeals that "patients rarely become addicted to
- 12          prescribed opioids," citing research by their KOL, Dr. Portenoy.<sup>92</sup>

135. These claims are contrary to longstanding scientific evidence. A 2016  
 8           opioid-prescription guideline issued by the CDC (the "2016 CDC Guideline")  
 9           explains that there is "[e]xtensive evidence" of the "possible harms of opioids  
 10          (including opioid use disorder [an alternative term for opioid addiction], [and]  
 11          overdose . . .)."<sup>93</sup> The 2016 CDC Guideline further explains that "[o]pioid pain  
 12          medication use presents serious risks, including overdose and opioid use disorder"  
 13          and that "continuing opioid therapy for 3 months substantially increases risk for  
 14          opioid use disorder."<sup>94</sup>

136. The FDA further exposed the falsity of Defendants' claims about the  
 16          low risk of addiction when it announced changes to the labels for extended-release  
 17          and long-acting ("ER/LA") opioids in 2013 and for immediate release ("IR")  
 18          opioids in 2016. In its announcements, the FDA found that "most opioid drugs  
 19          have 'high potential for abuse'" and that opioids "are associated with a substantial  
 20          risk of misuse, abuse, NOWS [neonatal opioid withdrawal syndrome], addiction,  
 21          overdose, and death." According to the FDA, because of the "known serious  
 22          risks associated with opioid use . . . the risk of abuse and diversion is high."

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24          <sup>92</sup> Brief of the American Pain Foundation, the National Pain Foundation, and the  
 25          National Foundation for the Treatment of Pain in Support of Appellant and  
 26          Reversal of the Conviction, *United States v. Hurowitz*, No. 05-4474 (4th Cir. Sept.  
 27          8, 2005) [hereinafter Brief of APF] at 9.

28          <sup>93</sup> Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic*  
 29          *Pain—United States, 2016*, Morbidity & Mortality Wkly. Rep., Mar. 18, 2016, at  
 30          15 [hereinafter 2016 CDC Guideline], <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>.

31          <sup>94</sup> *Id.* at 2, 25.

1 risks” associated with long-term opioid use, including “risks of addiction, abuse,  
 2 and misuse, even at recommended doses, and because of the greater risks of  
 3 overdose and death,” opioids should be used only “in patients for whom  
 4 alternative treatment options” like non-opioid drugs have failed.<sup>95</sup>

5       137. The State of New York, in a 2016 settlement agreement with Endo,  
 6 found that opioid “use disorders appear to be highly prevalent in chronic pain  
 7 patients treated with opioids, with up to 40% of chronic pain patients treated in  
 8 specialty and primary care outpatient centers meeting the clinical criteria for an  
 9 opioid use disorder.”<sup>96</sup> Endo had claimed on its [www.opana.com](http://www.opana.com) website that  
 10 “[m]ost healthcare providers who treat patients with pain agree that patients  
 11 treated with prolonged opioid medicines usually do not become addicted,” but the  
 12 State of New York found that Endo had no evidence for that statement. Consistent  
 13 with this, Endo agreed not to “make statements that . . . opioids generally are non-  
 14 addictive” or “that most patients who take opioids do not become addicted” in  
 15 New York. Endo remains free, however, to make those statements in this State.

16       138. In addition to mischaracterizing the highly addictive nature of the  
 17 drugs they were pushing, the Manufacturer Defendants also fostered a  
 18 fundamental misunderstanding of the signs of addiction. Specifically, the  
 19 Manufacturer Defendants misrepresented, to doctors and patients, that warning  
 20 signs and/or symptoms of addiction were, instead, signs of undertreated pain (i.e.  
 21

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22       <sup>95</sup> Letter from Janet Woodcock, M.D., Dir., Ctr. For Drug Evaluation and  
 23 Research, U.S. Food and Drug Admin., U.S. Dep’t of Health and Human Servs., to  
 24 Andrew Koldny, M.D., President, Physicians for Responsible Opioid Prescribing  
 25 (Sept. 10, 2013), [https://www.regulations.gov/contentStreamer?documentId=FDA-2012-P-0818-0793&attachmentNumber=1&contentType=pdf.](https://www.regulations.gov/contentStreamer?documentId=FDA-2012-P-0818-0793&attachmentNumber=1&contentType=pdf.;); Letter from Janet  
 26 Woodcock, M.D., Dir., Ctr. For Drug Evaluation and Research, U.S. Food and  
 27 Drug Admin., U.S. Dep’t of Health and Human Servs., to Peter R. Mathers &  
 28 Jennifer A. Davidson, Kleinfeld, Kaplan and Becker, LLP (Mar. 22, 2016),  
<https://www.regulations.gov/contentStreamer?documentId=FDA-2014-P-0205-0006&attachmentNumber=1&contentType=pdf.>

96 Assurance of Discontinuance, *In re Endo Health Solutions Inc. and Endo Pharm. Inc.* (Assurance No. 15-228), at 16,  
[https://ag.ny.gov/pdfs/Endo\\_AOD\\_030116-Fully\\_Executed.pdf.](https://ag.ny.gov/pdfs/Endo_AOD_030116-Fully_Executed.pdf.)

1 pseudoaddiction) – and instructed doctors to increase the opioid prescription dose  
 2 for patients who were already in danger.

3       139. To this end, one of Purdue’s employees, Dr. David Haddox, invented  
 4 a phenomenon called “pseudoaddiction.” KOL Dr. Portenoy popularized the term.  
 5 Examples of the false, misleading, deceptive, and unfair statements regarding  
 6 pseudoaddiction include:

- 7           a. Cephalon and Purdue sponsored *Responsible Opioid Prescribing*  
                  8 (2007), which taught that behaviors such as “requesting drugs by  
                  9 name,” “demanding or manipulative behavior,” seeing more than one  
                  10 doctor to obtain opioids, and hoarding,<sup>97</sup> are all signs of  
                  11 pseudoaddiction, rather than true addiction.<sup>98</sup> The 2012 edition,  
                  12 which remains available for sale online, continues to teach that  
                  13 pseudoaddiction is real.<sup>98</sup>
- 14           b. Janssen sponsored, funded, and edited the Let’s Talk Pain website,  
                  15 which in 2009 stated: “pseudoaddiction . . . refers to patient  
                  16 behaviors that may occur when pain is under-treated . . . .  
                  17 Pseudoaddiction is different from true addiction because such  
                  18 behaviors can be resolved with effective pain management.”
- 19           c. Endo sponsored a National Initiative on Pain Control (“NIPC”) CME  
                  20 program in 2009 entitled “Chronic Opioid Therapy: Understanding  
                  21 Risk While Maximizing Analgesia,” which, upon information and  
                  22 belief, promoted pseudoaddiction by teaching that a patient’s aberrant  
                  23 behavior was the result of untreated pain. Endo appears to have  
                  24 substantially controlled NIPC by funding NIPC projects; developing,  
                  25 specifying, and reviewing content; and distributing NIPC materials.
- 26           d. Purdue published a pamphlet in 2011 entitled *Providing Relief,*  
                  27 *Preventing Abuse*, which, upon information and belief, described  
                  28 pseudoaddiction as a concept that “emerged in the literature” to  
                  29 describe the inaccurate interpretation of [drug-seeking behaviors] in  
                  30 patients who have pain that has not been effectively treated.”
- 31           e. Upon information and belief, Purdue sponsored a CME program  
                  32 titled “Path of the Patient, Managing Chronic Pain in Younger Adults  
                  33 at Risk for Abuse”. In a role play, a chronic pain patient with a  
                  34 history of drug abuse tells his doctor that he is taking twice as many  
                  35 hydrocodone pills as directed. The narrator notes that because of  
                  36 pseudoaddiction, the doctor should not assume the patient is addicted  
                  37 even if he persistently asks for a specific drug, seems desperate,

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 27       <sup>97</sup> Scott M. Fishman, M.D., *Responsible Opioid Prescribing: A Physician’s Guide*  
 28 (2d ed. 2012).

29       <sup>98</sup> See Scott M. Fishman, M.D., *Responsible Opioid Prescribing: A Physician’s*  
 30 *Guide* (2d ed. 2012).

1 hoards medicine, or “overindulges in unapproved escalating doses.”  
 2 The doctor treats this patient by prescribing a high-dose, long-acting  
 3 opioid.

- 4 f. In 2010, Mallinckrodt sponsored an initiative “Collaborating and  
 5 Acting Responsibly to Ensure Safety (C.A.R.E.S.), through which it  
 6 published and promoted the book “Defeat Chronic Pain Now!” aimed  
 7 at chronic pain patients. The book, which is still available for sale,  
 8 and is promoted online at [www.defeatchronicpainnow.com](http://www.defeatchronicpainnow.com), teaches  
 9 laypeople that “pseudoaddiction” is “caused by their doctor not  
 10 appropriately prescribing the opioid medication.” It teaches that  
 11 “[p]seudoaddiction happens when a patient’s opioid medication is not  
 12 being prescribed in doses strong enough to provide good pain relief,  
 13 or if the drug is not being prescribed often enough throughout the  
 14 day. . . When a pseudoaddicted patient is prescribed the proper  
 15 amount of opioid medication, he or she doesn’t take any extra pills  
 16 because his or her pain is relieved.”

17 140. In the 2016 CDC Guideline, the CDC rejects the validity of the  
 18 pseudoaddiction fallacy invented by a Purdue employee as a reason to push more  
 19 opioid drugs onto already addicted patients.

20 141. In addition to misstating the addiction risk and inventing the  
 21 pseudoaddiction falsehood, a third category of false, deceptive, and unfair practice  
 22 is the Manufacturer Defendants’ false instructions that addiction risk screening  
 23 tools, patient contracts, urine drug screens, and similar strategies allow them to  
 24 reliably identify and safely prescribe opioids to patients predisposed to addiction.  
 25 These misrepresentations were especially insidious because the Manufacturer  
 26 Defendants aimed them at general practitioners and family doctors who lack the  
 27 time and expertise to closely manage higher-risk patients on opioids. The  
 28 Manufacturer Defendants’ misrepresentations made these doctors feel more  
 comfortable prescribing opioids to their patients, and patients more comfortable  
 starting on opioid therapy for chronic pain. Illustrative examples include:

- 29 a. Endo paid for a 2007 supplement in the *Journal of Family Practice*  
 30 written by a doctor who became a member of Endo’s speakers bureau  
 31 in 2010. The supplement, entitled *Pain Management Dilemmas in*  
*32 Primary Care: Use of Opioids*, emphasized the effectiveness of  
 33 screening tools, claiming that patients at high risk of addiction could  
 34 safely receive chronic opioid therapy using a “maximally structured  
 35 approach” involving toxicology screens and pill counts.
- 36 b. Purdue, upon information and belief, sponsored a 2011 webinar,  
 37 *Managing Patient’s Opioid Use: Balancing the Need and Risk*, which

1 claimed that screening tools, urine tests, and patient agreements  
 2 prevent “overuse of prescriptions” and “overdose deaths.”  
 3

- 4
- 5 c. As recently as 2015, upon information and belief, Purdue has  
 6 represented in scientific conferences that “bad apple” patients – and  
 7 not opioids – are the source of the addiction crisis and that once those  
 8 “bad apples” are identified, doctors can safely prescribe opioids  
 9 without causing addiction.

10 142. The 2016 CDC Guideline confirms the falsity of these claims. The  
 11 Guideline explains that there are no studies assessing the effectiveness of risk  
 12 mitigation strategies “for improving outcomes related to overdose, addiction,  
 13 abuse or misuse.”<sup>99</sup>

143. A fourth category of deceptive messaging regarding dangerous  
 15 opioids is the Manufacturer Defendants’ false assurances regarding the alleged  
 16 ease of eliminating opioid dependence. The Manufacturer Defendants falsely  
 17 claimed that opioid dependence can easily be addressed by tapering and that  
 18 opioid withdrawal is not a problem, but they failed to disclose the increased  
 19 difficulty of stopping opioids after long-term use. In truth, the 2016 CDC  
 20 Guideline explains that the symptoms of opioid withdrawal include abdominal  
 21 pain, vomiting, diarrhea, sweating, tremor, tachycardia, drug cravings, anxiety,  
 22 insomnia, spontaneous abortion and premature labor in pregnant women.<sup>100</sup>

23 144. The Manufacturer Defendants nonetheless downplayed the severity  
 24 of opioid detoxification. For example, upon information and belief, a CME  
 25 sponsored by Endo, entitled *Persistent Pain in the Older Adult*, claimed that  
 26 withdrawal symptoms can be avoided by tapering a patient’s opioid dose by 10%-  
 27 20% for 10 days. And Purdue sponsored APF’s *A Policymaker’s Guide to*  
 28 *Understanding Pain & Its Management*, which claimed that “[s]ymptoms of  
 29 physical dependence can often be ameliorated by gradually decreasing the dose of  
 30 medication during discontinuation” without mentioning any hardships that might

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99 *Id.* at 11.

100 *Id.* at 26.

1 occur.<sup>101</sup> Similarly, in the 2010 Mallinckrodt/C.A.R.E.S. publication “Defeat  
 2 Chronic Pain Now!” potential opioid users are advised that tolerance to opioids is  
 3 “easily remedied,” and that “[a]ll patients can be safely taken off opioid  
 4 medication if the dose is slowly tapered down by their doctor.”

5       145. A fifth category of false, deceptive, and unfair statements the  
 6 Manufacturer Defendants made to sell more drugs is that opioid dosages could be  
 7 increased indefinitely without added risk. The ability to escalate dosages was  
 8 critical to Defendants’ efforts to market opioids for long-term use to treat chronic  
 9 pain because, absent this misrepresentation, doctors would have abandoned  
 10 treatment when patients built up tolerance and lower dosages did not provide pain  
 11 relief. The Manufacturer Defendants’ deceptive claims include:

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- 13           a. Upon information and belief, Actavis’s predecessor created a patient  
                 brochure for Kadian in 2007 that stated, “Over time, your body may  
                 become tolerant of your current dose. You may require a dose  
                 adjustment to get the right amount of pain relief. This is not  
                 addiction.” Based on Actavis’s acquisition of its predecessor’s  
                 marketing materials along with the rights to Kadian, Actavis appears  
                 to have continued to use these materials in 2009 and beyond.
- 14           b. Cephalon and Purdue sponsored APF’s *Treatment Options: A Guide*  
                 *for People Living with Pain* (2007), which claims that some patients  
                 “need” a larger dose of an opioid, regardless of the dose currently  
                 prescribed. The guide stated that opioids have “no ceiling dose” and  
                 insinuated that they are therefore the most appropriate treatment for  
                 severe pain.<sup>102</sup> This publication is still available online.
- 15           c. Endo sponsored a website, “PainKnowledge,” which, upon  
                 information and belief, claimed in 2009 that opioid dosages may be  
                 increased until “you are on the right dose of medication for your  
                 pain.”
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25           <sup>101</sup> Am. Pain Found., *A Policymaker’s Guide to Understanding Pain and Its*  
 Management 6 (2011) [hereinafter APF, *Policymaker’s Guide*],  
<http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf>, at  
 32.

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27           <sup>102</sup> Am. Pain Found., *Treatment Options: A Guide for People Living in Pain* (2007)  
 [hereinafter APF, *Treatment Options*],  
<https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf>, at  
 12.

- d. Endo distributed a pamphlet edited by a KOL entitled *Understanding Your Pain: Taking Oral Opioid Analgesics* (2004 Endo Pharmaceuticals PM-0120). In Q&A format, it asked “If I take the opioid now, will it work later when I really need it?” The response is, “The dose can be increased. . . . You won’t ‘run out’ of pain relief.”<sup>103</sup>
  - e. Janssen sponsored a patient education guide entitled *Finding Relief: Pain Management for Older Adults* (2009), which was distributed by its sales force. This guide listed dosage limitations as “disadvantages” of other pain medicines but omitted any discussion of risks of increased opioid dosages.
  - f. Upon information and belief, Purdue’s In the Face of Pain website promoted the notion that if a patient’s doctor does not prescribe what, in the patient’s view, is a sufficient dosage of opioids, he or she should find another doctor who will.
  - g. Purdue sponsored APF’s *A Policymaker’s Guide to Understanding Pain & Its Management*, which taught that dosage escalations are “sometimes necessary,” and that “the need for higher doses of medication is not necessarily indicative of addiction,” but inaccurately downplayed the risks from high opioid dosages.<sup>104</sup>
- 
- h. In 2007, Purdue sponsored a CME entitled “Overview of Management Options” that was available for CME credit and available until at least 2012. The CME was edited by a KOL and taught that Non-steroidal Anti-inflammatory Drugs (“NSAIDs”) and other drugs, but not opioids, are unsafe at high dosages.
  - i. Purdue presented a 2015 paper at the College on the Problems of Drug Dependence, “the oldest and largest organization in the US dedicated to advancing a scientific approach to substance use and addictive disorders,” challenging the correlation between opioid dosage and overdose.<sup>105</sup>
  - j. Seeking to overturn the criminal conviction of a doctor for illegally prescribing opioids, the Manufacturer Defendants’ Front Groups APF and NFP argued in an *amicus* brief to the United States Fourth Circuit Court of Appeals that “there is no ‘ceiling dose’” for opioids.<sup>106</sup>

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<sup>103</sup> Margo McCaffery & Chris Pasero, Endo Pharm., *Understanding Your Pain: Taking Oral Opioid Analgesics* (Russell K Portenoy, M.D., ed., 2004).

<sup>104</sup> Am. Pain Found., *A Policymaker’s Guide to Understanding Pain and Its Management* 6 (2011) [hereinafter APF, *Policymaker’s Guide*], <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf>., at 32.

<sup>105</sup> The College on Problems of Drug Dependence, *About the College*, <http://cpdd.org> (last visited Aug. 21, 2017).

<sup>106</sup> Brief of APF, at 9.

k. In the 2010 Mallinckrodt/C.A.R.E.S. publication “Defeat Chronic Pain Now!”, potential opioid users are warned about the risk of “[p]seudoaddiction [b]ecause of a [l]ow [d]ose,” and advised that this condition may be corrected through the prescription of a higher dose. Similarly, the book recommends that for chronic pain patients, the opioid dose should be “gradually increased to find the best daily dose, as is done with all the other oral drugs.” The book discusses the risks of NSAIDs and other drugs at higher doses, but not explain this risk for opioids.

146. Once again, the 2016 CDC Guideline reveals that the Manufacturer Defendants' representations regarding opioids were lacking in scientific evidence. The 2016 CDC Guideline clarifies that the “[b]enefits of high-dose opioids for chronic pain are not established” while the “risks for serious harms related to opioid therapy increase at higher opioid dosage.”<sup>107</sup> More specifically, the CDC explains that “there is now an established body of scientific evidence showing that overdose risk is increased at higher opioid dosages.”<sup>108</sup> The CDC also states that there is an increased risk “for opioid use disorder, respiratory depression, and death at higher dosages.”<sup>109</sup> That is why the CDC advises doctors to “avoid increasing dosage” to above 90 morphine milligram equivalents per day.<sup>110</sup>

147. Defendants' deceptive marketing of the so-called abuse-deterrent properties of some of their opioids has created false impressions that these opioids can cure addiction and abuse.

148. The Manufacturer Defendants made misleading claims about the ability of their so-called abuse-deterrent opioid formulations to deter abuse. For example, Endo’s advertisements for the 2012 reformulation of Opana ER claimed that it was designed to be crush resistant, in a way that suggested it was more difficult to abuse. This claim was false. The FDA warned in a 2013 letter that Opana ER Extended-Release Tablets’ “extended-release features can be

<sup>107</sup> 2016 CDC Guideline at 22–23.

108 *Id.* at 23-24.

109 *Id.* at 21

110 *Id.* at 16

1 compromised, causing the medication to ‘dose dump,’ when subject to . . . forms  
2 of manipulation such as cutting, grinding, or chewing, followed by  
3 swallowing.”<sup>111</sup> Also troubling, Opana ER can be prepared for snorting using  
4 commonly available methods and “readily prepared for injection.”<sup>112</sup> The letter  
5 discussed “the troubling possibility that a higher (and rising) percentage of [Opana  
6 ER Extended-Release Tablet] abuse is occurring via injection.”<sup>113</sup> Endo’s own  
7 studies, which it failed to disclose, showed that Opana ER could still be ground  
8 and chewed. In June 2017, the FDA requested that Opana ER be removed from  
9 the market.

ii. The Manufacturer Defendants embarked upon a campaign of false, deceptive, and unfair assurances grossly overstating the benefits of the opioid drugs.

12        149. To convince doctors and patients that opioids should be used to treat  
13 chronic pain, the Manufacturer Defendants also had to persuade them that there  
14 was a significant upside to long-term opioid use. But as the CDC Guideline makes  
15 clear, “[n]o evidence shows a long-term benefit of opioids in pain and function  
16 versus no opioids for chronic pain with outcomes examined at least 1 year later  
17 (with most placebo-controlled randomized trials  $\leq$  6 weeks in duration)” and that  
18 other treatments were more or equally beneficial and less harmful than long-term  
19 opioid use.<sup>114</sup> The FDA, too, has recognized the lack of evidence to support long-  
20 term opioid use. Despite this, Defendants falsely and misleadingly touted the  
21 benefits of long-term opioid use and falsely and misleadingly suggested that these  
22 benefits were supported by scientific evidence.

<sup>25</sup> <sup>111</sup> Letter from Janet Woodcock, M.D., Dir., Ctr. For Drug Evaluation and  
<sup>26</sup> Research, U.S. Food and Drug Admin., U.S. Dep't of Health and Human Servs., to  
Robert Barto, Vice President, Reg. Affairs, Endo Pharm. Inc. (May 10, 2013), at 5.

27 | <sup>112</sup>*Id.* at 6.

27 | <sup>113</sup>Id at 6 n 21

28 | <sup>114</sup>*Ia.* at 3 hr  
<sup>114</sup>*Id.* at 15

1           150. Some illustrative examples of the Manufacturer Defendants' false  
 2 claims are:

- 3           a. Upon information and belief, Actavis distributed an advertisement  
         4 claiming that the use of Kadian to treat chronic pain would allow  
         5 patients to return to work, relieve "stress on your body and your  
         6 mental health," and help patients enjoy their lives.
- 7           b. Endo distributed advertisements that claimed that the use of Opana  
         8 ER for chronic pain would allow patients to perform demanding tasks  
         9 like construction work or work as a chef and portrayed seemingly  
         10 healthy, unimpaired subjects.
- 11           c. Janssen sponsored and edited a patient education guide entitled  
         12 *Finding Relief: Pain Management for Older Adults* (2009) – which  
         13 states as "a fact" that "opioids may make it easier for people to live  
         14 normally." The guide lists expected functional improvements from  
         15 opioid use, including sleeping through the night, returning to work,  
         16 recreation, sex, walking, and climbing stairs.
- 17           d. Janssen promoted Ultracet for everyday chronic pain and distributed  
         18 posters, for display in doctors' offices, of presumed patients in active  
         19 professions; the caption read, "Pain doesn't fit into their schedules."
- 20           e. Upon information and belief, Purdue ran a series of advertisements  
         21 for OxyContin in 2012 in medical journals entitled "Pain vignettes,"  
         22 which were case studies featuring patients with pain conditions  
         23 persisting over several months and recommending OxyContin for  
         24 them. The ads implied that OxyContin improves patients' function.
- 25           f. *Responsible Opioid Prescribing* (2007), sponsored and distributed by  
         26 Cephalon, Endo and Purdue, taught that relief of pain by opioids, by  
         27 itself, improved patients' function.
- 28           g. Cephalon and Purdue sponsored APF's *Treatment Options: A Guide*  
         29 for *People Living with Pain* (2007), which counseled patients that  
         30 opioids "give [pain patients] a quality of life we deserve."<sup>115</sup> This  
         31 publication is still available online.
- 32           h. Endo's NIPC website "PainKnowledge" claimed in 2009, upon  
         33 information and belief, that with opioids, "your level of function  
         34 should improve; you may find you are now able to participate in  
         35 activities of daily living, such as work and hobbies, that you were not  
         36 able to enjoy when your pain was worse." Elsewhere, the website  
         37 touted improved quality of life (as well as "improved function") as  
         38 benefits of opioid therapy. The grant request that Endo approved for  
         39 this project specifically indicated NIPC's intent to make misleading  
         40 claims about function, and Endo closely tracked visits to the site.

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27           115 Am. Pain Found., *Treatment Options: A Guide for People Living in Pain* (2007)  
 28 [hereinafter APF, *Treatment Options*],  
<https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf>.

- 1           i. Endo was the sole sponsor, through NIPC, of a series of CMEs  
2           entitled “Persistent Pain in the Older Patient.”<sup>116</sup> Upon information  
3           and belief, a CME disseminated via webcast claimed that chronic  
4           opioid therapy has been “shown to reduce pain and improve  
5           depressive symptoms and cognitive functioning.”
- 6           j. Janssen sponsored and funded a multimedia patient education  
7           campaign called “Let’s Talk Pain.” One feature of the campaign was  
8           to complain that patients were under-treated. In 2009, upon  
9           information and belief, a Janssen-sponsored website, part of the  
10          “Let’s Talk Pain” campaign, featured an interview edited by Janssen  
11          claiming that opioids allowed a patient to “continue to function.”
- 12          k. Purdue sponsored the development and distribution of APF’s *A  
13           Policymaker’s Guide to Understanding Pain & Its Management*,  
14           which claimed that “[m]ultiple clinical studies” have shown that  
15           opioids are effective in improving “[d]aily function,”  
16            “[p]sychological health,” and “[o]verall health-related quality of life  
17           for chronic pain.”<sup>117</sup> The Policymaker’s Guide was originally  
18           published in 2011.
- 19          l. Purdue’s, Cephalon’s, Endo’s, and Janssen’s sales representatives  
20           have conveyed and continue to convey the message that opioids will  
21           improve patient function.

13           151. As the FDA and other agencies have made clear for years, these  
14           claims have no support in the scientific literature.

15           152. In 2010, the FDA warned Actavis, in response to its advertising of  
16           Kadian described above, that “we are not aware of substantial evidence or  
17           substantial clinical experience demonstrating that the magnitude of the effect of  
18           the drug [Kadian] has in alleviating pain, taken together with any drug-related side  
19           effects patients may experience . . . results in any overall positive impact on a  
20           patient’s work, physical and mental functioning, daily activities, or enjoyment of  
21           life.”<sup>118</sup> And in 2008, upon information and belief, the FDA sent a warning letter  
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24           <sup>116</sup> E.g., NIPC, *Persistent Pain and the Older Patient* (2007),  
25           [https://www.painedu.org/Downloads/NIPC/Activities/B173\\_Providence\\_RI\\_%20Invite.pdf](https://www.painedu.org/Downloads/NIPC/Activities/B173_Providence_RI_%20Invite.pdf).

26           <sup>117</sup> Am. Pain Found., *A Policymaker’s Guide to Understanding Pain and Its  
27           Management* 6 (2011) [hereinafter APF, *Policymaker’s Guide*],  
28           <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf>., at  
29.

28           <sup>118</sup> Letter from Thomas Abrams, Dir., Div. of Drug Mktg., Advert., & Commc’ns,  
U.S. Food & Drug Admin., to Doug Boothe, CEO, Actavis Elizabeth LLC (Feb.

1 to an opioid manufacturer, making it clear “that [the claim that] patients who are  
 2 treated with the drug experience an improvement in their overall function, social  
 3 function, and ability to perform daily activities . . . has not been demonstrated by  
 4 substantial evidence or substantial clinical experience.”

5       153. The Manufacturer Defendants also falsely and misleadingly  
 6 emphasized or exaggerated the risks of competing medications like NSAIDs, so  
 7 that doctors and patients would look to opioids first for the treatment of chronic  
 8 pain. Once again, these misrepresentations by the Manufacturer Defendants  
 9 contravene pronouncements by and guidance from the FDA and CDC based on  
 10 the scientific evidence. Indeed, the FDA changed the labels for extended-release  
 11 and long-acting (“ER/LA”) opioids in 2013 and immediate-release (“IR”) opioids  
 12 in 2016 to state that opioids should only be used as a last resort “in patients for  
 13 which alternative treatment options” like non-opioid drugs “are inadequate.” And  
 14 the 2016 CDC Guideline states that NSAIDs, not opioids, should be the first-line  
 15 treatment for chronic pain, particularly arthritis and lower back pain.<sup>119</sup> Purdue  
 16 misleadingly promoted OxyContin as being unique among opioids in providing 12  
 17 continuous hours of pain relief with one dose. In fact, OxyContin does not last for  
 18 12 hours – a fact that Purdue has known at all times relevant to this action. Upon  
 19 information and belief, Purdue’s own research shows that OxyContin wears off in  
 20 under six hours in one quarter of patients and in under 10 hours in more than half.  
 21 This is because OxyContin tablets release approximately 40% of their active  
 22 medicine immediately, after which release tapers. This triggers a powerful initial  
 23 response, but provides little or no pain relief at the end of the dosing period, when  
 24 less medicine is released. This phenomenon is known as “end of dose” failure, and  
 25 the FDA found in 2008 that a “substantial proportion” of chronic pain patients  
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27       18, 2010),  
 28 <http://www.fdanews.com/ext/resources/files/archives/a/ActavisElizabethLLC.pdf>.  
<sup>119</sup> 2016 CDC Guideline at 12.

1 taking OxyContin experience it. This not only renders Purdue's promise of 12  
 2 hours of relief false and deceptive, it also makes OxyContin more dangerous  
 3 because the declining pain relief patients experience toward the end of each  
 4 dosing period drives them to take more OxyContin before the next dosing period  
 5 begins, quickly increasing the amount of drug they are taking and spurring  
 6 growing dependence.

7       154. Purdue's competitors were aware of this problem. For example, upon  
 8 information and belief, Endo ran advertisements for Opana ER referring to "real"  
 9 12-hour dosing. Nevertheless, Purdue falsely promoted OxyContin as if it were  
 10 effective for a full 12 hours. Upon information and belief, Purdue's sales  
 11 representatives continue to tell doctors that OxyContin lasts a full 12 hours.

12       155. Front Groups supported by Purdue likewise echoed these  
 13 representations. For example, in an amicus brief submitted to the Supreme Court  
 14 of Ohio by the American Pain Foundation, the National Foundation for the  
 15 Treatment of Pain and the Ohio Pain Initiative in support of Purdue, those amici  
 16 represented:

17           OxyContin is particularly useful for sustained long-term pain because  
 18 it comes in higher, compact pills with a slow release coating. OxyContin pills can work for 12 hours. This makes it easier for  
 19 patients to comply with dosing requirements without experiencing a roller-coaster of pain relief followed quickly by pain renewal that can  
 20 occur with shorter acting medications. It also helps the patient sleep  
 21 through the night, which is often impossible with short-acting  
 22 medications. For many of those serviced by Pain Care Amici,<sup>120</sup> OxyContin has been a miracle medication.

23       156. Cephalon deceptively marketed its opioids Actiq and Fentora for  
 24 chronic pain even though the FDA has expressly limited their use to the treatment  
 25 of cancer pain in opioid tolerant individuals. Both Actiq and Fentora are

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 27       <sup>120</sup> Reply Brief of Amicus Curiae of the American Pain Foundation, The National  
 28 Foundation for the Treatment of Pain and the Ohio Pain Initiative Supporting  
 Appellants, *Howland v. Purdue Pharma L.P.*, No. 2003-1538 (Ohio Apr. 13,  
 2004), 2004 WL 1637768, at \*4 (footnote omitted).

1 extremely powerful fentanyl-based IR opioids. Neither is approved for or has been  
 2 shown to be safe or effective for chronic pain. Indeed, the FDA expressly  
 3 prohibited Cephalon from marketing Actiq for anything but cancer pain, and  
 4 refused to approve Fentora for the treatment of chronic pain because of the  
 5 potential harm, including the high risk of “serious and life-threatening adverse  
 6 events” and abuse – which are greatest in non-cancer patients. The FDA also  
 7 issued a Public Health Advisory in 2007 emphasizing that Fentora should only be  
 8 used for cancer patients who are opioid-tolerant and should not be used for any  
 9 other conditions, such as migraines, post-operative pain, or pain due to injury.<sup>121</sup>  
 10 Specifically, the FDA advised that Fentora “is only approved for breakthrough  
 11 cancer pain in patients who are *opioid-tolerant*, meaning those patients who take a  
 12 regular, daily, around-the-clock narcotic pain medication.”<sup>122</sup>

13       157. Despite this, Cephalon conducted and continues to conduct a well-  
 14 funded campaign to promote Actiq and Fentora for chronic pain and other non-  
 15 cancer conditions for which it was not approved, appropriate, and for which it is  
 16 not safe. As part of this campaign, Cephalon used CMEs, speaker programs,  
 17 KOLs, journal supplements, and detailing by its sales representatives to give  
 18 doctors the false impression that Actiq and Fentora are safe and effective for  
 19 treating non-cancer pain. For example:

- 20           a. Cephalon paid to have a CME it sponsored, *Opioid-Based*  
           *Management of Persistent and Breakthrough Pain*, published in a  
           supplement of Pain Medicine News in 2009. The CME instructed  
           doctors that “[c]linically, broad classification of pain syndromes as  
           either cancer- or non-cancer-related has limited utility” and  
           recommended Actiq and Fentora for patients with chronic pain.
- 21           b. Upon information and belief, Cephalon’s sales representatives set up  
           hundreds of speaker programs for doctors, including many non-

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26       <sup>121</sup> See U.S. Food & Drug Admin., *Public Health Advisory: Important Information*  
 27       *for the Safe Use of Fentora (fentanyl buccal tablets)* (Sept. 26, 2007),  
 28       <https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm051273.htm>.

122 *Id.*

1 oncologists, which promoted Actiq and Fentora for the treatment of  
2 non-cancer pain.

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- 7 c. In December 2011, Cephalon widely disseminated a journal supplement entitled “Special Report: An Integrated Risk Evaluation and Mitigation Strategy for Fentanyl Buccal Tablet (FENTORA) and Oral Transmucosal Fentanyl Citrate (ACTIQ)” to Anesthesiology News, Clinical Oncology News, and Pain Medicine News – three publications that are sent to thousands of anesthesiologists and other medical professionals. The Special Report openly promotes Fentora for “multiple causes of pain” – and not just cancer pain.

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10 158. Cephalon’s deceptive marketing gave doctors and patients the false impression that Actiq and Fentora were not only safe and effective for treating chronic pain, but were also approved by the FDA for such uses.

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159. Purdue also unlawfully and unfairly failed to report or address illicit and unlawful prescribing of its drugs, despite knowing about it for years. Purdue’s sales representatives have maintained a database since 2002 of doctors suspected of inappropriately prescribing its drugs. Rather than report these doctors to state medical boards or law enforcement authorities (as Purdue is legally obligated to do) or cease marketing to them, Purdue used the list to demonstrate the high rate of diversion of OxyContin – the same OxyContin that Purdue had promoted as less addictive – in order to persuade the FDA to bar the manufacture and sale of generic copies of the drug because the drug was too likely to be abused. In an interview with the Los Angeles Times, Purdue’s senior compliance officer acknowledged that in five years of investigating suspicious pharmacies, Purdue failed to take action – even where Purdue employees personally witnessed the diversion of its drugs. The same was true of prescribers; despite its knowledge of illegal prescribing, Purdue did not report that a Los Angeles clinic prescribed more than 1.1 million OxyContin tablets and that Purdue’s district manager described it internally as “an organized drug ring” until years after law

1 enforcement shut it down. In doing so, Purdue protected its own profits at the  
2 expense of public health and safety.<sup>123</sup>

3       160. Like Purdue, Endo has been cited for its failure to set up an effective  
4 system for identifying and reporting suspicious prescribing. In its settlement  
5 agreement with Endo, the State of New York found that Endo failed to require  
6 sales representatives to report signs of abuse, diversion, and inappropriate  
7 prescribing; paid bonuses to sales representatives for detailing prescribers who  
8 were subsequently arrested or convicted for illegal prescribing; and failed to  
9 prevent sales representatives from visiting prescribers whose suspicious conduct  
10 had caused them to be placed on a no-call list.

11                   **3. The Manufacturer Defendants Targeted Susceptible Prescribers  
12 and Vulnerable Patient Populations.**

13       161. As a part of their deceptive marketing scheme, the Manufacturer  
14 Defendants identified and targeted susceptible prescribers and vulnerable patient  
15 populations in the U.S., including this State and Plaintiffs' Community. For  
16 example, the Manufacturer Defendants focused their deceptive marketing on  
17 primary care doctors, who were more likely to treat chronic pain patients and  
18 prescribe them drugs, but were less likely to be educated about treating pain and  
19 the risks and benefits of opioids and therefore more likely to accept the  
20 Manufacturer Defendants' misrepresentations.

21       162. The Manufacturer Defendants also targeted vulnerable patient  
22 populations like the elderly and veterans, who tend to suffer from chronic pain.  
23 The Manufacturer Defendants targeted these vulnerable patients even though the  
24 risks of long-term opioid use were significantly greater for them. For example, the  
25 2016 CDC Guideline observes that existing evidence confirms that elderly  
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28       <sup>123</sup> Harriet Ryan et al., *More Than 1 Million Oxycontin Pills Ended Up in the  
Hands of Criminals and Addicts. What the Drugmaker Knew*, L.A. Times, July 10,  
2016, <http://www.latimes.com/projects/la-me-oxycontin-part2/>.

1 patients taking opioids suffer from elevated fall and fracture risks, reduced renal  
 2 function and medication clearance, and a smaller window between safe and unsafe  
 3 dosages.<sup>124</sup> The 2016 CDC Guideline concludes that there must be “additional  
 4 caution and increased monitoring” to minimize the risks of opioid use in elderly  
 5 patients. *Id.* at 27. The same is true for veterans, who are more likely to use anti-  
 6 anxiety drugs (benzodiazepines) for post-traumatic stress disorder, which interact  
 7 dangerously with opioids.

8           **4. Insys Employed Fraudulent, Illegal, and Misleading Marketing  
 9           Schemes to Promote Subsys.**

10          163. Insys’s opioid, Subsys, was approved by the FDA in 2012 for  
 11 “management of breakthrough pain in adult cancer patients who are already  
 12 receiving and who are tolerant to around-the-clock opioid therapy for their  
 13 underlying persistent cancer pain.” Under FDA rules, Insys could only market  
 14 Subsys for this use. Subsys consists of the highly addictive narcotic, fentanyl,  
 15 administered via a sublingual (under the tongue) spray, which provides rapid-  
 16 onset pain relief. It is in the class of drugs described as Transmucosal Immediate-  
 17 Release Fentanyl (“TIRF”).

18          164. To reduce the risk of abuse, misuse, and diversion, the FDA  
 19 instituted a Risk Evaluation and Mitigation Strategy (“REMS”) for Subsys and  
 20 other TIRF products, such as Cephalon’s Actiq and Fentora. The purpose of  
 21 REMS was to educate “prescribers, pharmacists, and patients on the potential for  
 22 misuse, abuse, addiction, and overdose” for this type of drug and to “ensure safe  
 23 use and access to these drugs for patients who need them.”<sup>125</sup> Prescribers must  
 24 enroll in the TIRF REMS before writing a prescription for Subsys.

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<sup>124</sup> 2016 CDC Guideline at 13.

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<sup>125</sup> Press Release, FDA, *FDA Approves Shared System REMS for TIRF Products*,  
 Dec. 29, 2011.

1       165. Since its launch, Subsys has been an extremely expensive  
 2 medication, and its price continues to rise each year. Depending on a patient's  
 3 dosage and frequency of use, a month's supply of Subsys could cost in the  
 4 thousands of dollars.

5       166. Due to its high cost, in most instances prescribers must submit  
 6 Subsys prescriptions to insurance companies or health benefit payors for prior  
 7 authorization to determine whether they will pay for the drug prior to the patient  
 8 attempting to fill the prescription. According to the U.S. Senate Homeland  
 9 Security and Governmental Affairs Committee Minority Staff Report ("Staff  
 10 Report"), the prior authorization process includes "confirmation that the patient  
 11 had an active cancer diagnosis, was being treated by an opioid (and, thus, was  
 12 opioid tolerant), and was being prescribed Subsys to treat breakthrough pain that  
 13 the other opioid could not eliminate. If any one of these factors was not present,  
 14 the prior authorization would be denied . . ." <sup>126</sup>

15       167. These prior authorization requirements proved to be daunting.  
 16 Subsys received reimbursement approval in only approximately 30% of submitted  
 17 claims. In order to increase approvals, Insys created a prior authorization unit,  
 18 called the Insys Reimbursement Center ("IRC"), to obtain approval for Subsys  
 19 reimbursements. This unit employed a number of fraudulent and misleading  
 20 tactics to secure reimbursements, including falsifying medical histories of  
 21 patients, falsely claiming that patients had cancer, and providing misleading  
 22 information to insurers and payors regarding patients' diagnoses and medical  
 23 conditions.

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 27       <sup>126</sup> U.S. Senate Homeland Security & Governmental Affairs Committee, *Fueling*  
          *an Epidemic, Insys Therapeutics and the Systemic Manipulation of Prior*  
          *Authorization*, <https://www.documentcloud.org/documents/3987564-REPORT-Fueling-an-Epidemic-Insys-Therapeutics.html>.

1       168. Subsys has proved to be extremely profitable for Insys. Insys made  
 2 approximately \$330 million in net revenue from Subsys last year. Between 2013  
 3 and 2016, the value of Insys stock rose 296%.

4       169. Since its launch in 2012, Insys aggressively worked to grow its  
 5 profits through fraudulent, illegal, and misleading tactics, including its  
 6 reimbursement-related fraud. Through its sales representatives and other  
 7 marketing efforts, Insys deceptively promoted Subsys as safe and appropriate for  
 8 uses such as neck and back pain, without disclosing the lack of approval or  
 9 evidence for such uses, and misrepresented the appropriateness of Subsys for  
 10 treatment those conditions. It implemented a kickback scheme wherein it paid  
 11 prescribers for fake speakers programs in exchange for prescribing Subsys. All of  
 12 these fraudulent and misleading schemes had the effect of pushing Insys's  
 13 dangerous opioid onto patients who did not need it.

14       170. Insys incentivized its sales force to engage in illegal and fraudulent  
 15 conduct. Many of the Insys sales representatives were new to the pharmaceutical  
 16 industry and their base salaries were low compared to industry standard. The  
 17 compensation structure was heavily weighted toward commissions and rewarded  
 18 reps more for selling higher (and more expensive) doses of Subsys, a "highly  
 19 unusual" practice because most companies consider dosing a patient-specific  
 20 decision that should be made by a doctor.<sup>127</sup>

21       171. The Insys "speakers program" was perhaps its most widespread and  
 22 damaging scheme. A former Insys salesman, Ray Furchak, alleged in a qui tam  
 23 action that the sole purpose of the speakers program was "in the words of his then  
 24 supervisor Alec Burlakoff, 'to get money in the doctor's pocket.'" Furchak went  
 25 on to explain that "[t]he catch . . . was that doctors who increased the level of  
 26 Subsys prescriptions, and at higher dosages (such as 400 or 800 micrograms

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<sup>127</sup> *Id.*

1 instead of 200 micrograms), would receive the invitations to the program—and  
 2 the checks.”<sup>128</sup> It was a pay-to-prescribe program.

3       172. Insys’s sham speaker program and other fraudulent and illegal tactics  
 4 have been outlined in great detail in indictments and guilty pleas of Insys  
 5 executives, employees, and prescribers across the country, as well as in a number  
 6 of lawsuits against the company itself.

7       173. In May of 2015, two Alabama pain specialists were arrested and  
 8 charged with illegal prescription drug distribution, among other charges. The  
 9 doctors were the top prescribers of Subsys, though neither were oncologists.  
 10 According to prosecutors, the doctors received illegal kickbacks from Insys for  
 11 prescribing Subsys. Both doctors had prescribed Subsys to treat neck, back, and  
 12 joint pain. In February of 2016, a former Insys sales manager pled guilty to  
 13 conspiracy to commit health care fraud, including engaging in a kickback scheme  
 14 in order to induce one of these doctors to prescribe Subsys. The plea agreement  
 15 states that nearly all of the Subsys prescriptions written by the doctor were off-  
 16 label to non-cancer patients. In May of 2017, one of the doctors was sentenced to  
 17 20 years in prison.

18       174. In June of 2015, a nurse practitioner in Connecticut described as the  
 19 state’s highest Medicare prescriber of narcotics, pled guilty to receiving \$83,000  
 20 in kickbacks from Insys for prescribing Subsys. Most of her patients were  
 21 prescribed the drug for chronic pain. Insys paid the nurse as a speaker for more  
 22 than 70 dinner programs at approximately \$1,000 per event; however, she did not  
 23 give any presentations. In her guilty plea, the nurse admitted receiving the  
 24 speaker fees in exchange for writing prescriptions for Subsys.

25       175. In August of 2015, Insys settled a complaint brought by the Oregon  
 26 Attorney General. In its complaint, the Oregon Department of Justice cited Insys

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28       <sup>128</sup> Roddy Boyd, *Insys Therapeutics and the New ‘Killing It’”*, Southern  
 Investigative Reporting Foundation, The Investigator, April 24, 2015.

1 for, among other things, misrepresenting to doctors that Subsys could be used to  
 2 treat migraine, neck pain, back pain, and other uses for which Subsys is neither  
 3 safe nor effective, and using speaking fees as kickbacks to incentivize doctors to  
 4 prescribe Subsys.

5       176. In August of 2016, the State of Illinois sued Insys for similar  
 6 deceptive and illegal practices. The Complaint alleged that Insys marketed  
 7 Subsys to high-volume prescribers of opioid drugs instead of to oncologists whose  
 8 patients experienced the breakthrough cancer pain for which the drug is indicated.  
 9 The Illinois Complaint also details how Insys used its speaker program to pay  
 10 high volume prescribers to prescribe Subsys. The speaker events took place at  
 11 upscale restaurants in the Chicago area, and Illinois speakers received an  
 12 “honorarium” ranging from \$700 to \$5,100, and they were allowed to order as  
 13 much food and alcohol as they wanted. At most of the events, the “speaker” being  
 14 paid by Insys did not speak, and, on many occasions, the only attendees at the  
 15 events were the speaker and an Insys sales representative.

16       177. In December of 2016, six Insys executives and managers were  
 17 indicted and then, in October 2017, Insys’s founder and owner was arrested and  
 18 charged with multiple felonies in connection with an alleged conspiracy to bribe  
 19 practitioners to prescribe Subsys and defraud insurance companies. A U.S.  
 20 Department of Justice press release explained that, among other things: “Insys  
 21 executives improperly influenced health care providers to prescribe a powerful  
 22 opioid for patients who did not need it, and without complying with FDA  
 23 requirements, thus putting patients at risk and contributing to the current opioid  
 24 crisis.”<sup>129</sup> A Drug Enforcement Administration (“DEA”) Special Agent in Charge  
 25 further explained that: “Pharmaceutical companies whose products include

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27       28       <sup>129</sup> Press Release, DOJ, U.S. Attorney’s Office, Dist. of Mass., *Founder and Owner*  
*of Pharmaceutical Company Insys Arrested and Charged with Racketeering* (Oct.  
 26, 2017), available at <https://www.justice.gov/usao-ma/pr-founder-and-owner-pharmaceutical-company-insys-arrested-and-charged-racketeering>.

1 controlled medications that can lead to addiction and overdose have a special  
2 obligation to operate in a trustworthy, transparent manner, because their  
3 customers' health and safety and, indeed, very lives depend on it.”<sup>130</sup>

4                   **5. The Manufacturer Defendants made Materially Deceptive  
5                   Statements and Concealed Material Facts.**

6                   178. As alleged herein, the Manufacturer Defendants made and/or  
7 disseminated deceptive statements regarding material facts and further concealed  
8 material facts, in the course of manufacturing, marketing, and selling prescription  
9 opioids. The Manufacturer Defendants’ actions were intentional and/or unlawful.  
10 Such statements include, but are not limited to, those set out below and alleged  
11 throughout this Complaint.

12                   179. Defendant Purdue made and/or disseminated deceptive statements,  
13 and concealed material facts in such a way to make their statements deceptive,  
14 including, but not limited to, the following:

- 15                   a. Creating, sponsoring, and assisting in the distribution of patient  
16 education materials distributed to consumers that contained deceptive  
statements;
- 17                   b. Creating and disseminating advertisements that contained deceptive  
18 statements concerning the ability of opioids to improve function  
long-term and concerning the evidence supporting the efficacy of  
19 opioids long-term for the treatment of chronic non-cancer pain;
- 20                   c. Disseminating misleading statements concealing the true risk of  
addiction and promoting the deceptive concept of pseudoaddiction  
21 through Purdue’s own unbranded publications and on internet sites  
Purdue operated that were marketed to and accessible by consumers;
- 22                   d. Distributing brochures to doctors, patients, and law enforcement  
23 officials that included deceptive statements concerning the indicators  
of possible opioid abuse;
- 24                   e. Sponsoring, directly distributing, and assisting in the distribution of  
25 publications that promoted the deceptive concept of pseudoaddiction,  
even for high-risk patients;

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<sup>130</sup> *Id.*

- f. Endorsing, directly distributing, and assisting in the distribution of publications that presented an unbalanced treatment of the long-term and dose-dependent risks of opioids versus NSAIDs;
- g. Providing significant financial support to pro-opioid KOL doctors who made deceptive statements concerning the use of opioids to treat chronic non-cancer pain;
- h. Providing needed financial support to pro-opioid pain organizations that made deceptive statements, including in patient education materials, concerning the use of opioids to treat chronic non-cancer pain;
- i. Assisting in the distribution of guidelines that contained deceptive statements concerning the use of opioids to treat chronic non-cancer pain and misrepresented the risks of opioid addiction;
- j. Endorsing and assisting in the distribution of CMEs containing deceptive statements concerning the use of opioids to treat chronic non-cancer pain;
- k. Developing and disseminating scientific studies that misleadingly concluded opioids are safe and effective for the long-term treatment of chronic non-cancer pain and that opioids improve quality of life, while concealing contrary data;
- l. Assisting in the dissemination of literature written by pro-opioid KOLs that contained deceptive statements concerning the use of opioids to treat chronic noncancer pain;
- m. Creating, endorsing, and supporting the distribution of patient and prescriber education materials that misrepresented the data regarding the safety and efficacy of opioids for the long-term treatment of chronic non-cancer pain, including known rates of abuse and addiction and the lack of validation for long-term efficacy;
- n. Targeting veterans by sponsoring and disseminating patient education marketing materials that contained deceptive statements concerning the use of opioids to treat chronic non-cancer pain;
- o. Targeting the elderly by assisting in the distribution of guidelines that contained deceptive statements concerning the use of opioids to treat chronic non-cancer pain and misrepresented the risks of opioid addiction in this population;
- p. Exclusively disseminating misleading statements in education materials to hospital doctors and staff while purportedly educating them on new pain standards;
- q. Making deceptive statements concerning the use of opioids to treat chronic noncancer pain to prescribers through in-person detailing; and
- r. Withholding from law enforcement the names of prescribers Purdue believed to be facilitating the diversion of its opioid, while simultaneously marketing opioids to these doctors by disseminating

1 patient and prescriber education materials and advertisements and  
 2 CMEs they knew would reach these same prescribers.

3 180. Defendant Endo made and/or disseminated deceptive statements, and  
 4 concealed material facts in such a way to make their statements deceptive,  
 including, but not limited to, the following:

- 5 a. Creating, sponsoring, and assisting in the distribution of patient  
   education materials that contained deceptive statements;
- 6 b. Creating and disseminating advertisements that contained deceptive  
   statements concerning the ability of opioids to improve function  
   long-term and concerning the evidence supporting the efficacy of  
   opioids long-term for the treatment of chronic non-cancer pain;
- 7 c. Creating and disseminating paid advertisement supplements in  
   academic journals promoting chronic opioid therapy as safe and  
   effective for long term use for high risk patients;
- 8 d. Creating and disseminating advertisements that falsely and  
   inaccurately conveyed the impression that Endo's opioids would  
   provide a reduction in oral, intranasal, or intravenous abuse;
- 9 e. Disseminating misleading statements concealing the true risk of  
   addiction and promoting the misleading concept of pseudoaddiction  
   through Endo's own unbranded publications and on internet sites  
   Endo sponsored or operated;
- 10 f. Endorsing, directly distributing, and assisting in the distribution of  
   publications that presented an unbalanced treatment of the long-term  
   and dose-dependent risks of opioids versus NSAIDs;
- 11 g. Providing significant financial support to pro-opioid KOLs, who  
   made deceptive statements concerning the use of opioids to treat  
   chronic non-cancer pain;
- 12 h. Providing needed financial support to pro-opioid pain organizations –  
   including over \$5 million to the organization responsible for many of  
   the most egregious misrepresentations – that made deceptive  
   statements, including in patient education materials, concerning the  
   use of opioids to treat chronic non-cancer pain;
- 13 i. Targeting the elderly by assisting in the distribution of guidelines that  
   contained deceptive statements concerning the use of opioids to treat  
   chronic non-cancer pain and misrepresented the risks of opioid  
   addiction in this population;
- 14 j. Endorsing and assisting in the distribution of CMEs containing  
   deceptive statements concerning the use of opioids to treat chronic  
   non-cancer pain;
- 15 k. Developing and disseminating scientific studies that deceptively  
   concluded opioids are safe and effective for the long-term treatment  
   of chronic non-cancer pain and that opioids improve quality of life,  
   while concealing contrary data;

1. Directly distributing and assisting in the dissemination of literature written by pro-opioid KOLs that contained deceptive statements concerning the use of opioids to treat chronic non-cancer pain, including the concept of pseudoaddiction;
  - m. Creating, endorsing, and supporting the distribution of patient and prescriber education materials that misrepresented the data regarding the safety and efficacy of opioids for the long-term treatment of chronic non-cancer pain, including known rates of abuse and addiction and the lack of validation for long-term efficacy; and
  - n. Making deceptive statements concerning the use of opioids to treat chronic non-cancer pain to prescribers through in-person detailing.

181. Defendant Janssen made and/or disseminated deceptive statements, and concealed material facts in such a way to make their statements deceptive, including, but not limited to, the following:

- a. Creating, sponsoring, and assisting in the distribution of patient education materials that contained deceptive statements;
  - b. Directly disseminating deceptive statements through internet sites over which Janssen exercised final editorial control and approval stating that opioids are safe and effective for the long-term treatment of chronic non-cancer pain and that opioids improve quality of life, while concealing contrary data;
  - c. Disseminating deceptive statements concealing the true risk of addiction and promoting the deceptive concept of pseudoaddiction through internet sites over which Janssen exercised final editorial control and approval;
  - d. Promoting opioids for the treatment of conditions for which Janssen knew, due to the scientific studies it conducted, that opioids were not efficacious and concealing this information;
  - e. Sponsoring, directly distributing, and assisting in the dissemination of patient education publications over which Janssen exercised final editorial control and approval, which presented an unbalanced treatment of the long-term and dose dependent risks of opioids versus NSAIDs;
  - f. Providing significant financial support to pro-opioid KOLs, who made deceptive statements concerning the use of opioids to treat chronic non-cancer pain;
  - g. Providing necessary financial support to pro-opioid pain organizations that made deceptive statements, including in patient education materials, concerning the use of opioids to treat chronic non-cancer pain;
  - h. Targeting the elderly by assisting in the distribution of guidelines that contained deceptive statements concerning the use of opioids to treat chronic non-cancer pain and misrepresented the risks of opioid addiction in this population;

- 1        i. Targeting the elderly by sponsoring, directly distributing, and  
2           assisting in the dissemination of patient education publications  
3           targeting this population that contained deceptive statements about  
4           the risks of addiction and the adverse effects of opioids, and made  
5           false statements that opioids are safe and effective for the long-term  
6           treatment of chronic non-cancer pain and improve quality of life,  
7           while concealing contrary data;
- 8        j. Endorsing and assisting in the distribution of CMEs containing  
9           deceptive statements concerning the use of opioids to treat chronic  
10          non-cancer pain;
- 11       k. Directly distributing and assisting in the dissemination of literature  
12          written by pro-opioid KOLs that contained deceptive statements  
13          concerning the use of opioids to treat chronic non-cancer pain,  
14          including the concept of pseudoaddiction;
- 15       l. Creating, endorsing, and supporting the distribution of patient and  
16          prescriber education materials that misrepresented the data regarding  
17          the safety and efficacy of opioids for the long-term treatment of  
18          chronic non-cancer pain, including known rates of abuse and  
19          addiction and the lack of validation for long-term efficacy;
- 20       m. Targeting veterans by sponsoring and disseminating patient  
21          education marketing materials that contained deceptive statements  
22          concerning the use of opioids to treat chronic non-cancer pain; and
- 23       n. Making deceptive statements concerning the use of opioids to treat  
24          chronic non-cancer pain to prescribers through in-person detailing.

182. Defendant Cephalon made and/or disseminated untrue, false and  
19          deceptive statements, and concealed material facts in such a way to make their  
20          statements deceptive, including, but not limited to, the following:

- 21       a. Creating, sponsoring, and assisting in the distribution of patient  
22          education materials that contained deceptive statements;
- 23       b. Sponsoring and assisting in the distribution of publications that  
24          promoted the deceptive concept of pseudoaddiction, even for high-  
25          risk patients;
- 26       c. Providing significant financial support to pro-opioid KOL doctors  
27          who made deceptive statements concerning the use of opioids to treat  
28          chronic non-cancer pain and breakthrough chronic non-cancer pain;
- 29       d. Developing and disseminating scientific studies that deceptively  
30          concluded opioids are safe and effective for the long-term treatment  
31          of chronic non-cancer pain in conjunction with Cephalon's potent  
32          rapid-onset opioids;
- 33       e. Providing needed financial support to pro-opioid pain organizations  
34          that made deceptive statements, including in patient education  
35          materials, concerning the use of opioids to treat chronic non-cancer  
36          pain;

- 1 f. Endorsing and assisting in the distribution of CMEs containing  
2 deceptive statements concerning the use of opioids to treat chronic  
3 non-cancer pain;
- 4 g. Endorsing and assisting in the distribution of CMEs containing  
5 deceptive statements concerning the use of Cephalon's rapid-onset  
6 opioids;
- 7 h. Directing its marketing of Cephalon's rapid-onset opioids to a wide  
8 range of doctors, including general practitioners, neurologists, sports  
9 medicine specialists, and workers' compensation programs, serving  
10 chronic pain patients;
- 11 i. Making deceptive statements concerning the use of Cephalon's  
12 opioids to treat chronic non-cancer pain to prescribers through in-  
13 person detailing and speakers' bureau events, when such uses are  
14 unapproved and unsafe; and
- 15 j. Making deceptive statements concerning the use of opioids to treat  
16 chronic non-cancer pain to prescribers through in-person detailing  
17 and speakers' bureau events.

183. Defendant Actavis made and/or disseminated deceptive statements,  
19 and concealed material facts in such a way to make their statements deceptive,  
20 including, but not limited to, the following:

- 21 a. Making deceptive statements concerning the use of opioids to treat  
22 chronic non-cancer pain to prescribers through in-person detailing;
- 23 b. Creating and disseminating advertisements that contained deceptive  
24 statements that opioids are safe and effective for the long-term  
25 treatment of chronic non-cancer pain and that opioids improve  
26 quality of life;
- 27 c. Creating and disseminating advertisements that concealed the risk of  
28 addiction in the long-term treatment of chronic, non-cancer pain; and
- d. Developing and disseminating scientific studies that deceptively  
concluded opioids are safe and effective for the long-term treatment  
of chronic non-cancer pain and that opioids improve quality of life  
while concealing contrary data.

## 23       **6. The Manufacturer Defendants Fraudulently Concealed Their 24 Misconduct.**

25       184. The Manufacturer Defendants, both individually and collectively,  
26 made, promoted, and profited from their misrepresentations about the risks and  
27 benefits of opioids for chronic pain even though they knew that their  
28 misrepresentations were false and deceptive. The history of opioids, as well as  
research and clinical experience establish that opioids are highly addictive and are

1 responsible for a long list of very serious adverse outcomes. The FDA warned  
2 Defendants of this, and Defendants had access to scientific studies, detailed  
3 prescription data, and reports of adverse events, including reports of addiction,  
4 hospitalization, and death – all of which clearly described the harm from long-  
5 term opioid use and that patients were suffering from addiction, overdose, and  
6 death in alarming numbers. More recently, the FDA and CDC have issued  
7 pronouncements, based on medical evidence, that conclusively expose the falsity  
8 of Defendants' misrepresentations, and Endo and Purdue have recently entered  
9 into agreements in New York prohibiting them from making some of the same  
10 misrepresentations described in this Complaint.

11       185. At all times relevant to this Complaint, the Manufacturer Defendants  
12 took steps to avoid detection of and to fraudulently conceal their deceptive  
13 marketing and unlawful, unfair, and fraudulent conduct. For example, the  
14 Manufacturer Defendants disguised their role in the deceptive marketing of  
15 chronic opioid therapy by funding and working through third parties like Front  
16 Groups and KOLs. The Manufacturer Defendants purposefully hid behind the  
17 assumed credibility of these individuals and organizations and relied on them to  
18 vouch for the accuracy and integrity of the Manufacturer Defendants' false and  
19 deceptive statements about the risks and benefits of long-term opioid use for  
20 chronic pain. Defendants also never disclosed their role in shaping, editing, and  
21 approving the content of information and materials disseminated by these third  
22 parties. The Manufacturer Defendants exerted considerable influence on these  
23 promotional and "educational" materials in emails, correspondence, and meetings  
24 with KOLs, Front Groups, and public relations companies that were not, and have  
25 not yet become, public. For example, PainKnowledge.org, which is run by the  
26 NIPC, did not disclose Endo's involvement. Other Manufacturer Defendants, such  
27 as Purdue and Janssen, ran similar websites that masked their own role.  
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1       186. Finally, the Manufacturer Defendants manipulated their promotional  
2 materials and the scientific literature to make it appear that these documents were  
3 accurate, truthful, and supported by objective evidence when they were not. The  
4 Manufacturer Defendants distorted the meaning or import of studies they cited  
5 and offered them as evidence for propositions the studies did not support. The  
6 Manufacturer Defendants invented “pseudoaddiction” and promoted it to an  
7 unsuspecting medical community. The Manufacturer Defendants provided the  
8 medical community with false and misleading information about ineffectual  
9 strategies to avoid or control opioid addiction. The Manufacturer Defendants  
10 recommended to the medical community that dosages be increased, without  
11 disclosing the risks. The Manufacturer Defendants spent millions of dollars over a  
12 period of years on a misinformation campaign aimed at highlighting opioids’  
13 alleged benefits, disguising the risks, and promoting sales. The lack of support for  
14 the Manufacturer Defendants’ deceptive messages was not apparent to medical  
15 professionals who relied upon them in making treatment decisions, nor could it  
16 have been detected by the Plaintiffs or Plaintiffs’ Community. Thus, the  
17 Manufacturer Defendants successfully concealed from the medical community,  
18 patients, and health care payors facts sufficient to arouse suspicion of the claims  
19 that the Plaintiffs now assert. Plaintiffs did not know of the existence or scope of  
20 the Manufacturer Defendants’ industry-wide fraud and could not have acquired  
21 such knowledge earlier through the exercise of reasonable diligence.

22       **C. THE DISTRIBUTOR DEFENDANTS’ UNLAWFUL DISTRIBUTION**  
23           **OF OPIOIDS.**

24       187. The Distributor Defendants owe a duty under both federal law (21  
25 U.S.C. § 823, 21 CFR 1301.74) and California law (*see, e.g.*, Cal. Bus. & Prof.  
26 Code § 4169.1) to monitor, detect, investigate, refuse to fill, and report suspicious  
27 orders of prescription opioids originating from Plaintiffs’ Community as well as  
28

1 those orders which the Distributor Defendants knew or should have known were  
2 likely to be diverted into Plaintiffs' Community.

3       188. The foreseeable harm from a breach of these duties is the diversion of  
4 prescription opioids for nonmedical purposes.

5       189. Each Distributor Defendant repeatedly and purposefully breached its  
6 duties under state and federal law. Such breaches are a direct and proximate cause  
7 of the widespread diversion of prescription opioids for nonmedical purposes into  
8 Plaintiffs' Community.

9       190. The unlawful diversion of prescription opioids is a direct and  
10 proximate cause and/or substantial contributing factor to the opioid epidemic,  
11 prescription opioid abuse, addiction, morbidity and mortality in the State and in  
12 Plaintiffs' Community. This diversion and the epidemic are direct causes of harms  
13 for which Plaintiffs seek to recover here.

14       191. The opioid epidemic in the State, including *inter alia* in Plaintiffs'  
15 Community, remains an immediate ***hazard to public health and safety***.

16       192. The opioid epidemic in Plaintiffs' Community is a temporary and  
17 continuous ***public nuisance*** and remains unabated.

18       193. The Distributor Defendants intentionally continued their conduct, as  
19 alleged herein, with knowledge that such conduct was creating the opioid nuisance  
20 and causing the harms and damages alleged herein.

21           **1. Wholesale Drug Distributors Have a Duty under State and**  
22           **Federal Law to Guard Against, and Report, Unlawful Diversion**  
23           **and to Report and Prevent Suspicious Orders.**

24       194. As under federal law, opioids are a Schedule II controlled substance  
25 under California law. *See* Cal. Health & Safety Code § 11055. Opioids are  
26 categorized as "Schedule II" drugs because they have a "high potential for abuse"  
27 and the potential to cause "severe psychic or physical dependence" and/or "severe  
28 psychological . . . dependence." 21 U.S.C. § 812(b)(2)(A)-(C).

1       195. California law required Distributor Defendants to be licensed by the  
2 California State Board of Pharmacy. Cal. Bus. & Prof. Code § 4160; Cal. Bus. &  
3 Prof. Code § 4161. California law required Manufacturer Defendants to be  
4 licensed by the State Department of Health Services. Cal. Health & Safety Code §  
5 111615.

6       196. The California State Board of Pharmacy has the authority to “deny,  
7 revoke, or suspend any license” issued to out-of-state manufacturers or wholesale  
8 distributors who violate the Pharmacy Law or the state’s Sherman Food, Drug and  
9 Cosmetic Law. Cal. Bus. & Prof. Code § 4304.

10      197. It is unlawful under California law for a distributor or manufacturer  
11 to “furnish controlled substances for other than legitimate medical purposes.” Cal.  
12 Health & Safety Code § 11153.5.

13      198. The California State Board of Pharmacy has the authority to “take  
14 action against any holder of a license who is guilty of unprofessional conduct”  
15 which includes “clearly excessive furnishing of controlled substances” for other  
16 than legitimate medical purposes. Cal. Bus. & Prof. Code § 4301(e) (citing Cal.  
17 Health & Safety Code § 11153.5). “Factors to be considered in determining  
18 whether the furnishing of controlled substances is clearly excessive shall include,  
19 but not be limited to, the amount of controlled substances furnished, the previous  
20 ordering pattern of the customer (including size and frequency of orders), the type  
21 and size of the customer, and where and to whom the customer distributes its  
22 product.” *Id.*

23      199. Other examples of unprofessional conduct include procuring a  
24 license by fraud or misrepresentation, gross negligence, fraud, making or signing  
25 documents with false statements, and violating any state or federal statute or rule  
26 regulating controlled substances. Cal. Bus. & Prof. Code § 4301.

27      200. California requires manufacturers and distributors of controlled  
28 substances to maintain records of the manufacture and sale of dangerous drugs.

1     See Cal. Bus. & Prof. Code §§ 4081; 4161(c)(2)(A); 4332; Cal. Code Regs. tit. 16,  
2 §§ 1780(f); 1783(e).

3                 201. Furthermore, California law incorporates federal requirements set out  
4 under the Controlled Substance Act and related controlled substance laws and  
5 regulations. See Cal. Bus. & Prof. Code §§ 4160(d) (representative-in-charge of  
6 wholesaler is responsible for wholesaler's compliance with applicable state and  
7 federal laws); 4301(j) (unprofessional conduct includes violating federal laws  
8 related to controlled substances); 4301(o) (unprofessional conduct includes  
9 violating, attempting to violate, assisting in or abetting or conspiring to violate any  
10 applicable federal law); Cal. Code Regs. tit. 16, § 1780(f)(2) (records required for  
11 identifying, recording and reporting losses or thefts shall be in accordance with  
12 federal regulations).

13                 202. Each Distributor Defendant was further required to register with the  
14 DEA, pursuant to the federal Controlled Substance Act. See 21 U.S.C. § 823(b),  
15 (e); 28 C.F.R. § 0.100. Each Distributor Defendant is a “registrant” as a  
16 wholesale distributor in the chain of distribution of Schedule II controlled  
17 substances with a duty to comply with all security requirements imposed under  
18 that statutory scheme. California law adopts and incorporates those requirements,  
19 as set out above. See, e.g., Cal. Code Regs. tit. 16, 1780(f)(2).

20                 203. Each Distributor Defendant has an affirmative duty under federal and  
21 California law to act as a gatekeeper guarding against the diversion of the highly  
22 addictive, dangerous opioid drugs. Federal law requires that Distributors of  
23 Schedule II drugs, including opioids, must maintain “effective control against  
24 diversion of particular controlled substances into other than legitimate medical,  
25 scientific, and industrial channels.” 21 U.S.C. §§ 823(b)(1). California law  
26 requires that “[t]he following minimum standards shall apply to all wholesale  
27 establishments for which permits have been issued by the Board: . . . (c)(2) All  
28 facilities shall be equipped with a security system that will provide suitable

1 protection against theft and diversion.” Cal. Code Regs. Tit. 16 § 1780(c)(2). In  
2 addition, drug distributors shall “establish, maintain, and adhere to written policies  
3 and procedures, which shall be followed for the receipt, security, storage,  
4 inventory, and distribution of prescription drugs, including policies and  
5 procedures for identifying, recording, and reporting losses or thefts[.]” Cal. Code  
6 Regs. Tit. 16 § 1780(f)(1).

7       204. The California Legislature has found that “Protection of the public  
8 shall be the highest priority for the California State Board of Pharmacy in  
9 exercising its licensing, regulatory, and disciplinary functions. Whenever the  
10 protection of the public is inconsistent with other interests sought to be promoted,  
11 the protection of the public shall be paramount.” Cal. Bus. & Prof. Code § 4001.1.

12       205. Federal regulations and California law impose a non-delegable duty  
13 upon wholesale drug distributors to “design and operate a system to disclose to the  
14 registrant suspicious orders of controlled substances. The registrant [distributor]  
15 shall inform the Field Division Office of the Administration in his area of  
16 suspicious orders when discovered by the registrant. Suspicious orders include  
17 orders of unusual size, orders deviating substantially from a normal pattern, and  
18 orders of unusual frequency.” 21 C.F.R. § 1301.74(b). *See also* Cal. Bus. & Prof.  
19 Code § 4169.1 (“A wholesaler, upon discovery, shall notify the board in writing of  
20 any suspicious orders of controlled substances placed by a California-licensed  
21 pharmacy or wholesaler by providing the board a copy of the information that the  
22 wholesaler provides to the United States Drug Enforcement Administration.”);  
23 Cal. Health & Safety Code § 11153.5(c) (factors considered in determining if  
24 distributor or manufacturer furnished controlled substances with a conscious  
25 disregard that they were being used for other than legitimate medical purposes  
26 include the amount of controlled substances furnished, the size and frequency of  
27 previous orders, the type and size of customer and where the customer distributes  
28 the product).

1       206. “Suspicious orders” include orders of an unusual size, orders of  
2 unusual frequency or orders deviating substantially from a normal pattern. *See* 21  
3 CFR 1301.74(b); *see also* Cal. Bus. & Prof. Code § 4169.1. These criteria are  
4 disjunctive and are not all inclusive. For example, if an order deviates  
5 substantially from a normal pattern, the size of the order does not matter and the  
6 order should be reported as suspicious. Likewise, a wholesale distributor need not  
7 wait for a normal pattern to develop over time before determining whether a  
8 particular order is suspicious. The size of an order alone, regardless of whether it  
9 deviates from a normal pattern, is enough to trigger the wholesale distributor’s  
10 responsibility to report the order as suspicious. The determination of whether an  
11 order is suspicious depends not only on the ordering patterns of the particular  
12 customer but also on the patterns of the entirety of the wholesale distributor’s  
13 customer base and the patterns throughout the relevant segment of the wholesale  
14 distributor industry.

15       207. In addition to reporting all suspicious orders, distributors must also  
16 stop shipment on any order which is flagged as suspicious and only ship orders  
17 which were flagged as potentially suspicious if, after conducting due diligence,  
18 the distributor can determine that the order is not likely to be diverted into illegal  
19 channels. *See Southwood Pharm., Inc.*, 72 Fed. Reg. 36,487, 36,501 (Drug Enf’t  
20 Admin. July 3, 2007); *Masters Pharmaceutical, Inc. v. Drug Enforcement*  
21 *Administration*, No. 15-11355 (D.C. Cir. June 30, 2017). Regardless, all flagged  
22 orders must be reported. *Id.*

23       208. These prescription drugs are regulated for the purpose of providing a  
24 “closed” system **intended to reduce the widespread diversion of these drugs**  
25 **out of legitimate channels into the illicit market**, while at the same time

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27

28

1 providing the legitimate drug industry with a unified approach to narcotic and  
 2 dangerous drug control.<sup>131</sup>

3       209. Different entities supervise the discrete links in the chain that  
 4 separate a consumer from a controlled substance. Statutes and regulations define  
 5 each participant's role and responsibilities.<sup>132</sup>

6       210. As the DEA advised the Distributor Defendants in a letter to them  
 7 dated September 27, 2006, wholesale distributors are "one of the key components  
 8 of the distribution chain. If the closed system is to function properly ...  
 9 distributors must be vigilant in deciding whether a prospective customer can be  
 10 trusted to deliver controlled substances only for lawful purposes. This  
 11 responsibility is critical, as ... the illegal distribution of controlled substances has  
 12 a substantial and detrimental effect on the health and general welfare of the  
 13 American people."<sup>133</sup>

14

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15       <sup>131</sup> See 1970 U.S.C.C.A.N. 4566, 4571-72.

16       <sup>132</sup> Brief for Healthcare Distribution Management Association and National  
 17 Association of Chain Drug Stores as Amici Curiae in Support of Neither Party,  
*Masters Pharm., Inc. v. U.S. Drug Enf't Admin.* (No. 15-1335) (D.C. Cir. Apr. 4,  
 18 2016), 2016 WL 1321983, at \*22 [hereinafter Brief for HDMA and NACDS]. The  
 19 Healthcare Distribution Management Association (HDMA or HMA)—now known  
 20 as the Healthcare Distribution Alliance (HDA)—is a national, not-for-profit trade  
 21 association that represents the nation's primary, full-service healthcare distributors  
 22 whose membership includes, among others: AmerisourceBergen Drug  
 23 Corporation, Cardinal Health, Inc., and McKesson Corporation. *See generally*  
*HDA, About*, <https://www.healthcaredistribution.org/about> (last visited Aug. 21,  
 24 2017). The National Association of Chain Drug Stores (NACDS) is a national,  
 25 not-for-profit trade association that represents traditional drug stores and  
 26 supermarkets and mass merchants with pharmacies whose membership includes,  
 27 among others: Walgreen Company, CVS Health, Rite Aid Corporation and  
 28 Walmart. *See generally NACDS, Mission*, <https://www.nacds.org/ about/mission/> (last visited Aug. 21, 2017).

29       <sup>133</sup> See Letter from Joseph T. Rannazzisi, Deputy Assistant Adm'r, Office of  
 30 Diversion Control, Drug. Enf't Admin., U.S. Dep't of Justice, to Cardinal Health  
 31 (Sept. 27, 2006) [hereinafter Rannazzisi Letter] ("This letter is being sent to every  
 32 commercial entity in the United States registered with the Drug Enforcement  
 33 Agency (DEA) to distribute controlled substances. The purpose of this letter is to  
 34 reiterate the responsibilities of controlled substance distributors in view of the  
 35 prescription drug abuse problem our nation currently faces."), filed in *Cardinal*  
*Health, Inc. v. Holder*, No. 1:12-cv-00185-RBW (D.D.C. Feb. 10, 2012), ECF No.  
 36 14-51.

1           211. The Distributor Defendants have admitted that they are responsible  
2 for reporting suspicious orders.<sup>134</sup>

3           212. The DEA sent a letter to each of the Distributor Defendants on  
4 September 27, 2006, warning that it would use its authority to revoke and suspend  
5 registrations when appropriate. The letter expressly states that a distributor, *in*  
6 **addition** to reporting suspicious orders, has a “statutory responsibility to exercise  
7 due diligence to avoid filling suspicious orders that might be diverted into other  
8 than legitimate medical, scientific, and industrial channels.”<sup>135</sup> The letter also  
9 instructs that “distributors must be vigilant in deciding whether a prospective  
10 customer can be trusted to deliver controlled substances only for lawful  
11 purposes.”<sup>136</sup> The DEA warns that “even just one distributor that uses its DEA  
12 registration to facilitate diversion can cause enormous harm.”<sup>137</sup>

13           213. The DEA sent a second letter to each of the Distributor Defendants  
14 on December 27, 2007.<sup>138</sup> This letter reminds the Defendants of their statutory and  
15 regulatory duties to “maintain effective controls against diversion” and “design  
16 and operate a system to disclose to the registrant suspicious orders of controlled  
17 substances.”<sup>139</sup> The letter further explains:

18           The regulation also requires that the registrant inform the local DEA  
19 Division Office of suspicious orders when discovered by the  
registrant. Filing a monthly report of completed transactions (e.g.,  
20

21           <sup>134</sup> See Brief for HDMA and NACDS, 2016 WL 1321983, at \*4  
22 (“[R]egulations . . . in place for more than 40 years require distributors to report  
23 suspicious orders of controlled substances to DEA based on information readily  
available to them (e.g., a pharmacy’s placement of unusually frequent or large  
orders.”).

24           <sup>135</sup> Rannazzisi Letter, at 2.

25           <sup>136</sup> *Id.* at 1.

26           <sup>137</sup> *Id.* at 2.

27           <sup>138</sup> See Letter from Joseph T. Rannazzisi, Deputy Assistant Adm’r, Office of  
Diversion Control, Drug. Enf’t Admin., U.S. Dep’t of Justice, to Cardinal Health  
(Dec. 27, 2007), filed in *Cardinal Health, Inc. v. Holder*, No. 1:12-cv-00185-RBW  
(D.D.C. Feb. 10, 2012), ECF No. 14-8.

28           <sup>139</sup> *Id.*

1 “excessive purchase report” or “high unity purchases”) does not meet  
2 the regulatory requirement to report suspicious orders. Registrants are  
3 reminded that their responsibility does not end merely with the filing  
4 of a suspicious order report. Registrants must conduct an independent  
5 analysis of suspicious orders prior to completing a sale to determine  
6 whether the controlled substances are likely to be diverted from  
7 legitimate channels. Reporting an order as suspicious will not absolve  
8 the registrant of responsibility if the registrant knew, or should have  
9 known, that the controlled substances were being diverted.

10 The regulation specifically states that suspicious orders include orders  
11 of unusual size, orders deviating substantially from a normal pattern,  
12 and orders of an unusual frequency. These criteria are disjunctive and  
13 are not all inclusive. For example, if an order deviates substantially  
14 from a normal pattern, the size of the order does not matter and the  
15 order should be reported as suspicious. Likewise, a registrant need  
16 not wait for a “normal pattern” to develop over time before  
17 determining whether a particular order is suspicious. The size of an  
18 order alone, whether or not it deviates from a normal pattern, is  
19 enough to trigger the registrant’s responsibility to report the order as  
20 suspicious. The determination of whether an order is suspicious  
21 depends not only on the ordering patterns of the particular customer,  
22 but also on the patterns of the registrant’s customer base and the  
23 patterns throughout the segment of the regulated industry.

24 Registrants that rely on rigid formulas to define whether an order is  
25 suspicious may be failing to detect suspicious orders. For example, a  
26 system that identifies orders as suspicious only if the total amount of a  
27 controlled substance ordered during one month exceeds the amount  
28 ordered the previous month by a certain percentage or more is  
insufficient. This system fails to identify orders placed by a pharmacy  
if the pharmacy placed unusually large orders from the beginning of  
its relationship with the distributor. Also, this system would not  
identify orders as suspicious if the order were solely for one highly  
abused controlled substance if the orders never grew substantially.  
Nevertheless, ordering one highly abused controlled substance and  
little or nothing else deviates from the normal pattern of what  
pharmacies generally order.

29 When reporting an order as suspicious, registrants must be clear in  
30 their communication with DEA that the registrant is actually  
31 characterizing an order as suspicious. Daily, weekly, or monthly  
32 reports submitted by registrant indicating “excessive purchases” do  
33 not comply with the requirement to report suspicious orders, even if  
the registrant calls such reports “suspicious order reports.”

34 Lastly, registrants that routinely report suspicious orders, yet fill these  
35 orders without first determining that order is not being diverted into  
36 other than legitimate medical, scientific, and industrial channels, may  
37 be failing to maintain effective controls against diversion. Failure to  
38 maintain effective controls against diversion is inconsistent with the  
39 public interest as that term is used in 21 USC 823 and 824, and may

1 result in the revocation of the registrant's DEA Certificate of  
 2 Registration.<sup>140</sup>

3 Finally, the DEA letter references the Revocation of Registration issued in  
 4 *Southwood Pharmaceuticals, Inc.*, 72 Fed. Reg. 36,487-01 (July 3, 2007), which  
 5 discusses the obligation to report suspicious orders and "some criteria to use when  
 determining whether an order is suspicious."<sup>141</sup>

6 214. The Distributor Defendants admit that they "have not only statutory  
 7 and regulatory responsibilities to detect and prevent diversion of controlled  
 8 prescription drugs, but undertake such efforts as responsible members of  
 9 society."<sup>142</sup>

10 215. The Distributor Defendants knew they were required to monitor,  
 11 detect, and halt suspicious orders. Industry compliance guidelines established by  
 12 the Healthcare Distribution Management Association, the trade association of  
 13 pharmaceutical distributors, explain that distributors are "[a]t the center of a  
 14 sophisticated supply chain" and therefore "are uniquely situated to perform due  
 15 diligence in order to help support the security of the controlled substances they  
 16 deliver to their customers." The guidelines set forth recommended steps in the  
 17 "due diligence" process, and note in particular: If an order meets or exceeds a  
 18 distributor's threshold, as defined in the distributor's monitoring system, or is  
 19 otherwise characterized by the distributor as an order of interest, the distributor  
 20 should not ship to the customer, in fulfillment of that order, any units of the  
 21 specific drug code product as to which the order met or exceeded a threshold or as  
 22 to which the order was otherwise characterized as an order of interest.<sup>143</sup>

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<sup>140</sup> *Id.*

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<sup>141</sup> *Id.*

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<sup>142</sup> See Brief of HDMA, 2012 WL 1637016, at \*2.

28  
<sup>143</sup> Healthcare Distribution Management Association (HDMA) Industry  
 Compliance Guidelines: Reporting Suspicious Orders and Preventing Diversion of  
 Controlled Substances, filed in *Cardinal Health, Inc. v. Holder*, No. 12-5061 (D.C.  
 Cir. Mar. 7, 2012), Doc. No. 1362415 (App'x B).

1       216. Each of the Distributor Defendants sold prescription opioids,  
2 including hydrocodone and/or oxycodone, to retailers in Plaintiffs' Community  
3 and/or to retailers from which Defendants knew prescription opioids were likely  
4 to be diverted to Plaintiffs' Community.

5       217. Each Distributor Defendant owes a duty to monitor and detect  
6 suspicious orders of prescription opioids.

7       218. Each Distributor Defendant owes a duty under federal and state law  
8 to investigate and refuse suspicious orders of prescription opioids.

9       219. Each Distributor Defendant owes a duty under federal and state law  
10 to report suspicious orders of prescription opioids.

11       220. Each Distributor Defendant owes a duty under federal and state law  
12 to prevent the diversion of prescription opioids into illicit markets in the State and  
13 Plaintiffs' Community.

14       221. The foreseeable harm resulting from a breach of these duties is the  
15 diversion of prescription opioids for nonmedical purposes and subsequent plague  
16 of opioid addiction.

17       222. The foreseeable harm resulting from the diversion of prescription  
18 opioids for nonmedical purposes is abuse, addiction, morbidity and mortality in  
19 Plaintiffs' Community and the damages caused thereby.

20       **2. The Distributor Defendants Breached Their Duties.**

21       223. Because distributors handle such large volumes of controlled  
22 substances, and are the first major line of defense in the movement of legal  
23 pharmaceutical controlled substances from legitimate channels into the illicit  
24 market, it is incumbent on distributors to maintain effective controls to prevent  
25 diversion of controlled substances. Should a distributor deviate from these checks  
26 and balances, the closed system collapses.<sup>144</sup>

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<sup>144</sup> See Rannazzisi Decl. ¶ 10, filed in *Cardinal Health, Inc. v. Holder*, No. 1:12-cv-00185-RBW (D.D.C. Feb. 10, 2012), ECF No. 14-2.

1       224. The sheer volume of prescription opioids distributed to pharmacies in  
2 the Plaintiffs' Community, and/or to pharmacies from which the Distributor  
3 Defendants knew the opioids were likely to be diverted into Plaintiffs'  
4 Community, is excessive for the medical need of the community and facially  
5 suspicious. Some red flags are so obvious that no one who engages in the  
6 legitimate distribution of controlled substances can reasonably claim ignorance of  
7 them.<sup>145</sup>

8           225. The Distributor Defendants failed to report “suspicious orders”  
9 originating from Plaintiffs’ Community, or which the Distributor Defendants  
10 knew were likely to be diverted to Plaintiffs’ Community, to the federal and state  
11 authorities, including the DEA and/or the state Board of Pharmacy.

12        226. The Distributor Defendants unlawfully filled suspicious orders of  
13 unusual size, orders deviating substantially from a normal pattern and/or orders of  
14 unusual frequency in Plaintiffs' Community, and/or in areas from which the  
15 Distributor Defendants knew opioids were likely to be diverted to Plaintiffs'  
16 Community.

17        227. The Distributor Defendants breached their duty to monitor, detect,  
18 investigate, refuse and report suspicious orders of prescription opiates originating  
19 from Plaintiffs' Community, and/or in areas from which the Distributor  
20 Defendants knew opioids were likely to be diverted to Plaintiffs' Community.

21        228. The Distributor Defendants breached their duty to maintain effective  
22 controls against diversion of prescription opiates into other than legitimate  
23 medical, scientific, and industrial channels.

24        229. The Distributor Defendants breached their duty to “design and  
25 operate a system to disclose to the registrant suspicious orders of controlled

<sup>145</sup> Masters Pharmaceuticals, Inc., 80 Fed. Reg. 55,418-01, 55,482 (Sept. 15, 2015) (citing Holiday CVS, L.L.C., d/b/a CVS/Pharmacy Nos. 219 and 5195, 77 Fed. Reg. 62,316, 62,322 (2012)).

1 substances” and failed to inform the authorities including the DEA of suspicious  
2 orders when discovered, in violation of their duties under federal and state law.

3       230. The Distributor Defendants breached their duty to exercise due  
4 diligence to avoid filling suspicious orders that might be diverted into channels  
5 other than legitimate medical, scientific and industrial channels.<sup>146</sup>

6       231. The federal and state laws at issue here are public safety laws.

7       232. The Distributor Defendants’ violations of public safety statutes  
8 constitute *prima facie* evidence of negligence under State law.

9       233. The Distributor Defendants supplied prescription opioids to  
10 obviously suspicious physicians and pharmacies, enabled the illegal diversion of  
11 opioids, aided criminal activity, and disseminated massive quantities of  
12 prescription opioids into the black market.

13       234. The unlawful conduct by the Distributor Defendants is purposeful  
14 and intentional. The Distributor Defendants refuse to abide by the duties imposed  
15 by federal and state law which are required to legally acquire and maintain a  
16 license to distribute prescription opiates.

17       235. The Distributor Defendants acted with actual malice in breaching  
18 their duties, *i.e.*, they have acted with a conscious disregard for the rights and  
19 safety of other persons, and said actions have a great probability of causing  
20 substantial harm.

21       236. The Distributor Defendants’ repeated shipments of suspicious orders,  
22 over an extended period of time, in violation of public safety statutes, and without  
23 reporting the suspicious orders to the relevant authorities demonstrates wanton,  
24 willful, or reckless conduct or criminal indifference to civil obligations affecting  
25 the rights of others.

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<sup>146</sup> See *Cardinal Health, Inc. v. Holder*, 846 F. Supp. 2d 203, 206 (D.D.C. 2012).

1                   **3. The Distributor Defendants Have Sought to Avoid and Have**  
 2                   **Misrepresented their Compliance with Their Legal Duties.**

3                 237. The Distributor Defendants have repeatedly misrepresented their  
 4                 compliance with their legal duties under state and federal law and have wrongfully  
 5                 and repeatedly disavowed those duties in an effort to mislead regulators and the  
 6                 public regarding the Distributor Defendants' compliance with their legal duties.

7                 238. Distributor Defendants have refused to recognize any duty beyond  
 8                 *reporting* suspicious orders. In *Masters Pharmaceuticals*, the HDMA, a trade  
 9                 association run by the Distributor Defendants, and the NACDS submitted amicus  
 10                briefs regarding the legal duty of wholesale distributors. Inaccurately denying the  
 11                legal duties that the wholesale drug industry has been tragically recalcitrant in  
 12                performing, they argued as follows:

- 13                a. The Associations complained that the “DEA has required distributors  
                   not only to report suspicious orders, but to *investigate* orders (e.g., by  
                   interrogating pharmacies and physicians) and take action to *halt*  
                   suspicious orders before they are filled.”<sup>147</sup>
- 14                b. The Associations argued that, “DEA now appears to have changed its  
                   position to require that distributors not only *report* suspicious orders,  
                   but *investigate* and *halt* suspicious orders. Such a change in agency  
                   position must be accompanied by an acknowledgment of the change  
                   and a reasoned explanation for it. In other words, an agency must  
                   display awareness that it *is* changing position and show that there are  
                   good reasons for the new policy. This is especially important here,  
                   because imposing intrusive obligations on distributors threatens to  
                   disrupt patient access to needed prescription medications.”<sup>148</sup>
- 15                c. The Associations alleged (inaccurately) that nothing “requires  
                   distributors to *investigate* the legitimacy of orders, or to *halt*  
                   shipment of any orders deemed to be suspicious.”<sup>149</sup>
- 16                d. The Association complained that the purported “practical infeasibility  
                   of requiring distributors to *investigate* and *halt* suspicious orders (as  
                   well as *report* them) underscores the importance of ensuring that  
                   DEA has complied with the APA before attempting to impose such  
                   duties.”<sup>150</sup>

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<sup>147</sup> Brief for HDMA and NACDS, 2016 WL 1321983, at \*4–5.

27                <sup>148</sup> *Id.* at \*8 (citations and quotation marks omitted).

28                <sup>149</sup> *Id.* at \*14.

<sup>150</sup> *Id.* at \*22.

- e. The Associations alleged (inaccurately) that “DEA’s regulations [] sensibly impose[] a duty on distributors simply to *report* suspicious orders, but left it to DEA and its agents to investigate and halt suspicious orders.”<sup>151</sup>
  - f. Also inaccurately, the Associations argued that, “[i]mposing a duty on distributors – which lack the patient information and the necessary medical expertise – to investigate and halt orders may force distributors to take a shot-in-the-dark approach to complying with DEA’s demands.”<sup>152</sup>

239. The positions taken by the trade groups is emblematic of the position taken by the Distributor Defendants in a futile attempt to deny their legal obligations to prevent diversion of the dangerous drugs.<sup>153</sup>

9       240. The Court of Appeals for the District of Columbia recently issued its  
10 opinion affirming that a wholesale drug distributor does, in fact, have duties  
11 beyond reporting. *Masters Pharm., Inc. v. Drug Enf't Admin.*, 861 F.3d 206 (D.C.  
12 Cir. 2017). The D.C. Circuit Court upheld the revocation of Master  
13 Pharmaceutical's license and determined that DEA regulations require that in  
14 addition to reporting suspicious orders, distributors must "decline to ship the  
15 order, or conduct some 'due diligence' and—if it is able to determine that the  
16 order is not likely to be diverted into illegal channels—ship the order." *Id.* at 212.  
17 Master Pharmaceutical was in violation of legal requirements because it failed to  
18 conduct necessary investigations and filled suspicious orders. *Id.* at 218–19, 226.  
19 A distributor's investigation must dispel all the red flags giving rise to suspicious  
20 circumstances prior to shipping a suspicious order. *Id.* at 226. The Circuit Court  
21 also rejected the argument made by the HDMA and NACDS (quoted above), that,  
22 allegedly, the DEA had created or imposed new duties. *Id.* at 220.

23           241. Wholesale Distributor McKesson has recently been forced to  
24 specifically admit to breach of its duties to monitor, report, and prevent suspicious

26 | <sup>151</sup> *Id.* at \*24–25.

27 | <sup>152</sup> *Id.* at \*26.

<sup>153</sup> See Brief of HDMA, 2012 WL 1637016, at \*3 (arguing the wholesale distributor industry “does not know the rules of the road because” they claim (inaccurately) that the “DEA has not adequately explained them”).

1 orders. Pursuant to an Administrative Memorandum of Agreement (“2017  
 2 Agreement”) entered into between McKesson and the DEA in January 2017,  
 3 McKesson admitted that, at various times during the period from January 1, 2009  
 4 through the effective date of the Agreement (January 17, 2017) it “did not identify  
 5 or report to [the] DEA certain orders placed by certain pharmacies which should  
 6 have been detected by McKesson as suspicious based on the guidance contained  
 7 in the DEA Letters.”<sup>154</sup> Further, the 2017 Agreement specifically finds that  
 8 McKesson “distributed controlled substances to pharmacies even though those  
 9 McKesson Distribution Centers should have known that the pharmacists  
 10 practicing within those pharmacies had failed to fulfill their corresponding  
 11 responsibility to ensure that controlled substances were dispensed pursuant to  
 12 prescriptions issued for legitimate medical purposes by practitioners acting in the  
 13 usual course of their professional practice, as required by 21 C.F.R  
 14 § 1306.04(a).”<sup>155</sup> McKesson admitted that, during this time period, it “failed to  
 15 maintain effective controls against diversion of particular controlled substances  
 16 into other than legitimate medical, scientific and industrial channels by sales to  
 17 certain of its customers in violation of the CSA and the CSA’s implementing  
 18 regulations, 21 C.F.R. Part 1300 *et seq.*, at the McKesson Distribution Centers.”<sup>156</sup>  
 19 Due to these violations, McKesson agreed that its authority to distribute controlled  
 20 substances from numerous facilities would be partially suspended.<sup>157</sup>

21       242. The 2017 Memorandum of Agreement followed a 2008 Settlement  
 22 Agreement in which McKesson also admitted failure to report suspicious orders of  
 23  
 24

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25       <sup>154</sup> See Administrative Memorandum of Agreement between the U.S. Dep’t of  
 26 Justice, the Drug Enf’t Admin., and the McKesson Corp. (Jan. 17, 2017),  
<https://www.justice.gov/opa/press-release/file/928476/download>.

27       <sup>155</sup> *Id.* at 4.

28       <sup>156</sup> *Id.*

29       <sup>157</sup> *Id.* at 6.

1 controlled substances to the DEA.<sup>158</sup> In the 2008 Settlement Agreement,  
 2 McKesson “recognized that it had a duty to monitor its sales of all controlled  
 3 substances and report suspicious orders to DEA,” but had failed to do so.<sup>159</sup> The  
 4 2017 Memorandum of Agreement documents that McKesson continued to breach  
 5 its admitted duties by “fail[ing] to properly monitor its sales of controlled  
 6 substances and/or report suspicious orders to DEA, in accordance with  
 7 McKesson’s obligations.”<sup>160</sup> As a result of these violations, McKesson was fined  
 8 and required to pay to the United States \$150,000,000.<sup>161</sup>

9       243. Even though McKesson had been sanctioned in 2008 for failure to  
 10 comply with its legal obligations regarding controlling diversion and reporting  
 11 suspicious orders, and even though McKesson had specifically agreed in 2008 that  
 12 it would no longer violate those obligations, McKesson continued to violate the  
 13 laws in contrast to its written agreement not to do so.

14       244. Because of the Distributor Defendants’ refusal to abide by their legal  
 15 obligations, the DEA has repeatedly taken administrative action to attempt to  
 16 force compliance. For example, in May 2014, the United States Department of  
 17 Justice, Office of the Inspector General, Evaluation and Inspections Divisions,  
 18 reported that the DEA issued final decisions in 178 registrant actions between  
 19 2008 and 2012.<sup>162</sup> The Office of Administrative Law Judges issued a  
 20

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21       <sup>158</sup> *Id.* at 4.

22       <sup>159</sup> *Id.*

23       <sup>160</sup> *Id.*; see also Settlement Agreement and Release between the U.S. and  
 24 McKesson Corp., at 5 (Jan. 17, 2017) [hereinafter 2017 Settlement Agreement and  
 25 Release] (“McKesson acknowledges that, at various times during the Covered  
 26 Time Period [2009-2017], it did not identify or report to DEA certain orders placed  
 27 by certain pharmacies, which should have been detected by McKesson as  
 28 suspicious, in a manner fully consistent with the requirements set forth in the 2008  
 MOA.”), <https://www.justice.gov/opa/press-release/file/928471/download>.

27       <sup>161</sup> See 2017 Settlement Agreement and Release, at 6.

28       <sup>162</sup> Evaluation and Inspections Div., Office of the Inspector Gen., U.S. Dep’t of  
 29 Justice, *The Drug Enforcement Administration’s Adjudication of Registrant  
 Actions* 6 (2014), <https://oig.justice.gov/reports/2014/e1403.pdf>.

1 recommended decision in a total of 117 registrant actions before the DEA issued  
 2 its final decision, including 76 actions involving orders to show cause and 41  
 3 actions involving immediate suspension orders.<sup>163</sup> These actions include the  
 4 following:

- 5 a. On April 24, 2007, the DEA issued an *Order to Show Cause and*  
*6 Immediate Suspension Order* against the AmerisourceBergen  
*7 Orlando, Florida distribution center (“Orlando Facility”)* alleging  
*failure to maintain effective controls against diversion of controlled*  
*substances. On June 22, 2007, AmerisourceBergen entered into a*  
*settlement that resulted in the suspension of its DEA registration;*
- 8 b. On November 28, 2007, the DEA issued an *Order to Show Cause*  
*9 and Immediate Suspension Order* against the Cardinal Health  
*Auburn, Washington Distribution Center (“Auburn Facility”)* for  
*failure to maintain effective controls against diversion of*  
*hydrocodone;*
- 10 c. On December 5, 2007, the DEA issued an *Order to Show Cause and*  
*11 Immediate Suspension Order* against the Cardinal Health Lakeland,  
*12 Florida Distribution Center (“Lakeland Facility”)* for failure to  
*maintain effective controls against diversion of hydrocodone;*
- 13 d. On December 7, 2007, the DEA issued an *Order to Show Cause and*  
*14 Immediate Suspension Order* against the Cardinal Health Swedesboro,  
*15 New Jersey Distribution Center (“Swedesboro Facility”)* for failure to maintain  
*effective controls against diversion of hydrocodone;*
- 16 e. On January 30, 2008, the DEA issued an *Order to Show Cause and*  
*17 Immediate Suspension Order* against the Cardinal Health Stafford,  
*18 Texas Distribution Center (“Stafford Facility”)* for failure to maintain  
*effective controls against diversion of hydrocodone;*
- 19 f. On May 2, 2008, McKesson Corporation entered into an  
*20 Administrative Memorandum of Agreement* (“2008 MOA”) with the  
*21 DEA which provided that McKesson would “maintain a compliance*  
*22 program designed to detect and prevent the diversion of controlled*  
*23 substances, inform DEA of suspicious orders required by 21 C.F.R. §*  
*24 1301.74(b), and follow the procedures established by its Controlled*  
*25 Substance Monitoring Program”;*
- 26 g. On September 30, 2008, Cardinal Health entered into a *Settlement*  
*27 and Release Agreement and Administrative Memorandum of*  
*28 Agreement* with the DEA related to its Auburn Facility, Lakeland  
*Facility, Swedesboro Facility and Stafford Facility. The document*  
*also referenced allegations by the DEA that Cardinal failed to*  
*maintain effective controls against the diversion of controlled*  
*substances at its distribution facilities located in McDonough,*

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<sup>163</sup> *Id.*

Georgia (“McDonough Facility”), Valencia, California (“Valencia Facility”) and Denver, Colorado (“Denver Facility”);

- h. On February 2, 2012, the DEA issued an *Order to Show Cause and Immediate Suspension Order* against the Cardinal Health Lakeland, Florida Distribution Center ("Lakeland Facility") for failure to maintain effective controls against diversion of oxycodone;
    - i. On December 23, 2016, Cardinal Health agreed to pay a \$44 million fine to the DEA to resolve the civil penalty portion of the administrative action taken against its Lakeland, Florida Distribution Center; and
    - j. On January 5, 2017, McKesson Corporation entered into an *Administrative Memorandum Agreement* with the DEA wherein it agreed to pay a \$150 million civil penalty for violation of the 2008 MOA as well as failure to identify and report suspicious orders at its facilities in Aurora CO, Aurora IL, Delran NJ, LaCrosse WI, Lakeland FL, Landover MD, La Vista NE, Livonia MI, Methuen MA, Santa Fe Springs CA, Washington Courthouse OH and West Sacramento CA.

245. Rather than abide by their non-delegable duties under public safety laws, the Distributor Defendants, individually and collectively through trade groups in the industry, pressured the U.S. Department of Justice to “halt” prosecutions and lobbied Congress to strip the DEA of its ability to immediately suspend distributor registrations. The result was a “sharp drop in enforcement actions” and the passage of the “Ensuring Patient Access and Effective Drug Enforcement Act” which, ironically, raised the burden for the DEA to revoke a distributor’s license from “imminent harm” to “immediate harm” and provided the industry the right to “cure” any violations of law before a suspension order can be issued.<sup>164</sup>

<sup>164</sup> See Lenny Bernstein & Scott Higham, *Investigation: The DEA Slowed Enforcement While the Opioid Epidemic Grew Out of Control*, Wash. Post, Oct. 22, 2016, [https://www.washingtonpost.com/investigations/the-dea-slowed-enforcement-while-the-opioid-epidemic-grew-out-of-control/2016/10/22/aea2bf8e-7f71-11e6-8d13-d7c704ef9fd9\\_story.html](https://www.washingtonpost.com/investigations/the-dea-slowed-enforcement-while-the-opioid-epidemic-grew-out-of-control/2016/10/22/aea2bf8e-7f71-11e6-8d13-d7c704ef9fd9_story.html); Lenny Bernstein & Scott Higham, *Investigation: U.S. Senator Calls for Investigation of DEA Enforcement Slowdown Amid Opioid Crisis*, Wash. Post, Mar. 6, 2017, [https://www.washingtonpost.com/investigations/us-senator-calls-for-investigation-of-dea-enforcement-slowdown/2017/03/06/5846ee60-028b-11e7-b1e9-a05d3c21f7cf\\_story.html](https://www.washingtonpost.com/investigations/us-senator-calls-for-investigation-of-dea-enforcement-slowdown/2017/03/06/5846ee60-028b-11e7-b1e9-a05d3c21f7cf_story.html); Eric Eyre, *DEA Agent: “We Had No Leadership” in WV Amid Flood of Pain Pills*, Charleston Gazette-Mail, Feb. 18, 2017, <http://www.wvgazettemail.com/news/20170218/dea-agent-we-had-no-leadership-in-wv-amid-flood-of-pain-pills->.

1       246. In addition to taking actions to limit regulatory prosecutions and  
 2 suspensions, the Distributor Defendants undertook to fraudulently convince the  
 3 public that they were complying with their legal obligations, including those  
 4 imposed by licensing regulations. Through such statements, the Distributor  
 5 Defendants attempted to assure the public they were working to curb the opioid  
 6 epidemic.

7       247. For example, a Cardinal Health executive claimed that it uses  
 8 “advanced analytics” to monitor its supply chain, and represented that it was being  
 9 “as effective and efficient as possible in constantly monitoring, identifying, and  
 10 eliminating any outside criminal activity.”<sup>165</sup> Given the sales volumes and the  
 11 company’s history of violations, this executive was either not telling the truth, or,  
 12 if Cardinal Health had such a system, it ignored the results.

13       248. Similarly, Defendant McKesson publicly stated that it has a “best-in-  
 14 class controlled substance monitoring program to help identify suspicious orders,”  
 15 and claimed it is “deeply passionate about curbing the opioid epidemic in our  
 16 country.”<sup>166</sup> Again, given McKesson’s historical conduct, this statement is either  
 17 false, or the company ignored outputs of the monitoring program.

18       249. By misleading the public about the effectiveness of their controlled  
 19 substance monitoring programs, the Distributor Defendants successfully  
 20 concealed the facts sufficient to arouse suspicion of the claims that the Plaintiffs  
 21 now assert. The Plaintiffs did not know of the existence or scope of Defendants’  
 22  
 23

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24       <sup>165</sup> Lenny Bernstein et al., *How Drugs Intended for Patients Ended Up in the*  
 25 *Hands of Illegal Users: “No One Was Doing Their Job,”* Wash. Post, Oct. 22,  
 26 2016, [https://www.washingtonpost.com/investigations/how-drugs-intended-for-patients-ended-up-in-the-hands-of-illegal-users-no-one-was-doing-their-job/2016/10/22/10e79396-30a7-11e6-8ff7-7b6c1998b7a0\\_story.html](https://www.washingtonpost.com/investigations/how-drugs-intended-for-patients-ended-up-in-the-hands-of-illegal-users-no-one-was-doing-their-job/2016/10/22/10e79396-30a7-11e6-8ff7-7b6c1998b7a0_story.html).

27       <sup>166</sup> Scott Higham et al., *Drug Industry Hired Dozens of Officials from the DEA as the Agency Tried to Curb Opioid Abuse,* Wash. Post, Dec. 22, 2016,  
 28 [https://www.washingtonpost.com/investigations/key-officials-switch-sides-from-dea-to-pharmaceutical-industry/2016/12/22/55d2e938-c07b-11e6-b527-949c5893595e\\_story.html](https://www.washingtonpost.com/investigations/key-officials-switch-sides-from-dea-to-pharmaceutical-industry/2016/12/22/55d2e938-c07b-11e6-b527-949c5893595e_story.html).

1 industry-wide fraud and could not have acquired such knowledge earlier through  
2 the exercise of reasonable diligence.

3        250. Meanwhile, the opioid epidemic rages unabated in the Nation, the  
4 State, and in Plaintiffs' Community.

5        251. The epidemic still rages because the fines and suspensions imposed  
6 by the DEA do not change the conduct of the industry. The distributors, including  
7 the Distributor Defendants, pay fines as a cost of doing business in an industry  
8 that generates billions of dollars in annual revenue. They hold multiple DEA  
9 registration numbers and when one facility is suspended, they simply ship from  
10 another facility.

11        252. The wrongful actions and omissions of the Distributor Defendants  
12 which have caused the diversion of opioids and which have been a substantial  
13 contributing factor to and/or proximate cause of the opioid crisis are alleged in  
14 greater detail in the racketeering allegations below.

15        253. The Distributor Defendants have abandoned their duties imposed  
16 under federal and state law, taken advantage of a lack of DEA law enforcement,  
17 and abused the privilege of distributing controlled substances in the State and  
18 Plaintiffs' Community.

#### **4. The National Retail Pharmacies Were on Notice of and Contributed to Illegal Diversion of Prescription Opioids**

21        254. National retail pharmacy chains earned enormous profits by flooding  
22 the country with prescription opioids.<sup>167</sup> They were keenly aware of the  
23 oversupply of prescription opioids through the extensive data and information  
24 they developed and maintained as both distributors and dispensaries. Yet, instead

<sup>27</sup> <sup>167</sup> The allegations contained in this Complaint are based, in part, on discovery that  
<sup>28</sup> is in its infancy. Plaintiffs do not have access to transactional ARCos data for  
California. Accordingly, Plaintiffs reserve their right to further amend this  
complaint to add supporting allegations, claims and parties.

1 of taking any meaningful action to stem the flow of opioids into communities,  
2 they continued to participate in the oversupply and profit from it.

3       255. Each of the National Retail Pharmacies does substantial business  
4 throughout the United States. This business includes the distribution and  
5 dispensing of prescription opioids.

6       256. On information and belief, the National Retail Pharmacies distributed  
7 and dispensed substantial quantities of prescription opioids, including fentanyl,  
8 hydrocodone, and oxycodone in California. In addition, they distributed and  
9 dispensed substantial quantities of prescription opioids in other states, and these  
10 drugs were diverted from these other states to California. The National Retail  
11 Pharmacies failed to take meaningful action to stop this diversion despite their  
12 knowledge of it, and contributed substantially to the diversion problem.

13       257. The National Retail Pharmacies developed and maintained extensive  
14 data on opioids they distributed and dispensed. Through this data, National Retail  
15 Pharmacies had direct knowledge of patterns and instances of improper  
16 distribution, prescribing, and use of prescription opioids in communities  
17 throughout the country, and in California in particular. They used the data to  
18 evaluate their own sales activities and workforce. On information and belief, the  
19 National Retail Pharmacies also provided Defendants with data regarding, *inter*  
20 *alia*, individual doctors in exchange for rebates or other forms of consideration.  
21 The National Retail Pharmacies' data is a valuable resource that they could have  
22 used to help stop diversion, but failed to do so.

23           **a. The National Retail Pharmacies Have a Duty to Prevent  
24           Diversion**

25       258. Each participant in the supply chain of opioid distribution, including  
26 the National Retail Pharmacies, is responsible for preventing diversion of  
27 prescription opioids into the illegal market by, among other things, monitoring  
28 and reporting suspicious activity.

1       259. The National Retail Pharmacies, like manufacturers and other  
2 distributors, are registrants under the CSA. 21 C.F.R. § 1301.11. Under the CSA,  
3 pharmacy registrants are required to “provide effective controls and procedures to  
4 guard against theft and diversion of controlled substances.” See 21 C.F.R. §  
5 1301.71(a). In addition, 21 C.F.R. § 1306.04(a) states, “[t]he responsibility for the  
6 proper prescribing and dispensing of controlled substances is upon the prescribing  
7 practitioner, but a corresponding responsibility rests with the pharmacist who fills  
8 the prescription.” Because pharmacies themselves are registrants under the CSA,  
9 the duty to prevent diversion lies with the pharmacy entity, not the individual  
10 pharmacist alone.

11       260. The DEA, among others, has provided extensive guidance to  
12 pharmacies concerning their duties to the public. The guidance advises  
13 pharmacies how to identify suspicious orders and other evidence of diversion.

14       261. Suspicious pharmacy orders include orders of unusually large size,  
15 orders that are disproportionately large in comparison to the population of a  
16 community served by the pharmacy, orders that deviate from a normal pattern  
17 and/or orders of unusual frequency and duration, among others.

18       262. Additional types of suspicious orders include: (1) prescriptions  
19 written by a doctor who writes significantly more prescriptions (or in larger  
20 quantities or higher doses) for controlled substances compared to other  
21 practitioners in the area; (2) prescriptions which should last for a month in  
22 legitimate use, but are being refilled on a shorter basis; (3) prescriptions for  
23 antagonistic drugs, such as depressants and stimulants, at the same time; (4)  
24 prescriptions that look “too good” or where the prescriber’s handwriting is too  
25 legible; (5) prescriptions with quantities or doses that differ from usual medical  
26 usage; (6) prescriptions that do not comply with standard abbreviations and/or  
27 contain no abbreviations; (7) photocopied prescriptions; or (8) prescriptions  
28

1 containing different handwriting. Most of the time, these attributes are not  
2 difficult to detect and should be easily recognizable by pharmacies.

3 263. Suspicious pharmacy orders are red flags for if not direct evidence of  
4 diversion.

5 264. Other signs of diversion can be observed through data gathered,  
6 consolidated, and analyzed by the National Retail Pharmacies themselves. That  
7 data allows them to observe patterns or instances of dispensing that are potentially  
8 suspicious, of oversupply in particular stores or geographic areas, or of prescribers  
9 or facilities that seem to engage in improper prescribing.

10 265. According to industry standards, if a pharmacy finds evidence of  
11 prescription diversion, the local Board of Pharmacy and DEA must be contacted.

12 266. Despite their legal obligations as registrants under the CSA, the  
13 National Retail Pharmacies allowed widespread diversion to occur—and they did  
14 so knowingly.

15 267. Performance metrics and prescription quotas adopted by the National  
16 Retail Pharmacies for their retail stores contributed to their failure. Under CVS's  
17 Metrics System, for example, pharmacists are directed to meet high goals that  
18 make it difficult, if not impossible, to comply with applicable laws and  
19 regulations. There is no measurement for pharmacy accuracy or customer safety.  
20 Moreover, the bonuses for pharmacists are calculated, in part, on how many  
21 prescriptions that pharmacist fills within a year. The result is both deeply  
22 troubling and entirely predictable: opioids flowed out of National Retail  
23 Pharmacies and into communities throughout the country. The policies remained  
24 in place even as the epidemic raged.

25 268. Upon information and belief, this problem was compounded by the  
26 Pharmacies' failure to adequately train their pharmacists and pharmacy  
27 technicians on how to properly and adequately handle prescriptions for opioid  
28 painkillers, including what constitutes a proper inquiry into whether a prescription

1 is legitimate, whether a prescription is likely for a condition for which the FDA  
2 has approved treatments with opioids, and what measures and/or actions to take  
3 when a prescription is identified as phony, false, forged, or otherwise illegal, or  
4 when suspicious circumstances are present, including when prescriptions are  
5 procured and pills supplied for the purpose of illegal diversion and drug  
6 trafficking.

7       269. Upon information and belief, the National Retail Pharmacies also  
8 failed to adequately use data available to them to identify doctors who were  
9 writing suspicious numbers of prescriptions and/or prescriptions of suspicious  
10 amounts of opioids, or to adequately use data available to them to do statistical  
11 analysis to prevent the filling of prescriptions that were illegally diverted or  
12 otherwise contributed to the opioid crisis.

13       270. Upon information and belief, the National Retail Pharmacies failed to  
14 analyze: (a) the number of opioid prescriptions filled by individual pharmacies  
15 relative to the population of the pharmacy's community; (b) the increase in opioid  
16 sales relative to past years; (c) the number of opioid prescriptions filled relative to  
17 other drugs; and (d) the increase in annual opioid sales relative to the increase in  
18 annual sales of other drugs.

19       271. Upon information and belief, the National Retail Pharmacies also  
20 failed to conduct adequate internal or external audits of their opioid sales to  
21 identify patterns regarding prescriptions that should not have been filled and to  
22 create policies accordingly, or if they conducted such audits, they failed to take  
23 any meaningful action as a result.

24       272. Upon information and belief, the National Retail Pharmacies also  
25 failed to effectively respond to concerns raised by their own employees regarding  
26 inadequate policies and procedures regarding the filling of opioid prescriptions.

27       273. The National Retail Pharmacies were, or should have been, fully  
28 aware that the quantity of opioids being distributed and dispensed by them was

1 untenable, and in many areas patently absurd; yet, they did not take meaningful  
2 action to investigate or to ensure that they were complying with their duties and  
3 obligations under the law with regard to controlled substances.

4           **b. Multiple Enforcement Actions against the National Retail  
5           Pharmacies Confirm their Compliance Failures.**

6           274. The National Retail Pharmacies have long been on notice of their  
7 failure to abide by state and federal law and regulations governing the distribution  
8 and dispensing of prescription opioids. Indeed, several of the National Retail  
9 Pharmacies have been repeatedly penalized for their illegal prescription opioid  
10 practices. Upon information and belief, based upon the widespread nature of these  
11 violations, these enforcement actions are the product of, and confirm, national  
12 policies and practices of the National Retail Pharmacies.

13           **i. CVS**

14           275. CVS is one of the largest companies in the world, with annual  
15 revenue of more than \$150 billion. According to news reports, it manages  
16 medications for nearly 90 million customers at 9,700 retail locations. CVS could  
17 be a force for good in connection with the opioid crisis, but like other Defendants,  
18 CVS sought profits over people.

19           276. CVS is a repeat offender and recidivist: the company has paid fines  
20 totaling over \$40 million as the result of a series of investigations by the DEA and  
21 the United States Department of Justice (“DOJ”). It nonetheless treated these fines  
22 as the cost of doing business and has allowed its pharmacies to continue  
23 dispensing opioids in quantities significantly higher than any plausible medical  
24 need would require, and to continue violating its recordkeeping and dispensing  
25 obligations under the CSA.

26           277. As recently as July 2017, CVS entered into a \$5 million settlement  
27 with the U.S. Attorney’s Office for the Eastern District of California regarding  
28

1 allegations that its pharmacies failed to keep and maintain accurate records of  
2 Schedule II, III, IV, and V controlled substances.<sup>168</sup>

3 278. This fine was preceded by numerous others throughout the country.

4 279. In February 2016, CVS paid \$8 million to settle allegations made by  
5 the DEA and the DOJ that from 2008-2012, CVS stores and pharmacists in  
6 Maryland violated their duties under the CSA and filled prescriptions with no  
7 legitimate medical purpose.<sup>169</sup>

8 280. In October 2016, CVS paid \$600,000 to settle allegations by the DOJ  
9 that stores in Connecticut failed to maintain proper records in accordance with the  
10 CSA.<sup>170</sup>

11 281. In September 2016, CVS entered into a \$795,000 settlement with the  
12 Massachusetts Attorney General wherein CVS agreed to require pharmacy staff to  
13 access the state's prescription monitoring program website and review a patient's  
14 prescription history before dispensing certain opioid drugs.<sup>171</sup>

15 282. In June 2016, CVS agreed to pay the DOJ \$3.5 million to resolve  
16 allegations that 50 of its stores violated the CSA by filling forged prescriptions for  
17

19  
20 <sup>168</sup> Press Release, U.S. Attorney's Office E. Dist. of Cal., *CVS Pharmacy Inc. Pays*  
21 *\$5M to Settle Alleged Violations of the Controlled Substance Act*, U.S. Dep't of  
22 Just. (July 11, 2017), <https://www.justice.gov/usao-edca/pr/cvs-pharmacy-inc-pays-5m-settle-alleged-violations-controlled-substance-act>.

23 <sup>169</sup> Press Release, U.S. Attorney's Office Dist. of Md., *United States Reaches \$8*  
24 *Million Settlement Agreement with CVS for Unlawful Distribution of Controlled*  
25 *Substances*, U.S. Dep't of Just. (Feb. 12, 2016), <https://www.justice.gov/usao-md/pr/united-states-reaches-8-million-settlement-agreement-cvs-unlawful-distribution-controlled>.

26 <sup>170</sup> Press Release, U.S. Attorney's Office Dist. of Conn., *CVS Pharmacy Pays*  
27 *\$600,000 to Settle Controlled Substances Act Allegations*, U.S. Dep't of Just. (Oct.  
28 20, 2016), <https://www.justice.gov/usao-ct/pr/cvs-pharmacy-pays-600000-settle-controlled-substances-act-allegations>.

29 <sup>171</sup> Dialynn Dwyer, *CVS will pay \$795,000, strengthen policies around dispensing*  
30 *opioids in agreement with state*, Boston.com (Sept. 1, 2016),  
31 <https://www.boston.com/news/local-news/2016/09/01/cvs-will-pay-795000-strengthen-policies-around-dispensing-opioids-in-agreement-with-state>.

1 controlled substances—mostly addictive painkillers—more than 500 times  
 2 between 2011 and 2014.<sup>172</sup>

3       283. In August 2015, CVS entered into a \$450,000 settlement with the  
 4 U.S. Attorney’s Office for the District of Rhode Island to resolve allegations that  
 5 several of its Rhode Island stores violated the CSA by filling invalid prescriptions  
 6 and maintaining deficient records. The United States alleged that CVS retail  
 7 pharmacies in Rhode Island filled a number of forged prescriptions with invalid  
 8 DEA numbers, and filled multiple prescriptions written by psychiatric nurse  
 9 practitioners for hydrocodone, despite the fact that these practitioners were not  
 10 legally permitted to prescribe that drug. Additionally, the government alleged that  
 11 CVS had recordkeeping deficiencies.<sup>173</sup>

12       284. In May 2015, CVS agreed to pay a \$22 million penalty following a  
 13 DEA investigation that found that employees at two pharmacies in Sanford,  
 14 Florida, had dispensed prescription opioids, “based on prescriptions that had not  
 15 been issued for legitimate medical purposes by a health care provider acting in the  
 16 usual course of professional practice. CVS also acknowledged that its retail  
 17 pharmacies had a responsibility to dispense only those prescriptions that were  
 18 issued based on legitimate medical need.”<sup>174</sup>

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22       <sup>172</sup> Press Release, U.S. Attorney’s Office Dist. of Mass., *CVS to Pay \$3.5 Million*  
 23 *to Resolve Allegations that Pharmacists Filled Fake Prescriptions*, U.S. Dep’t of  
 24 Just. (June 30, 2016), <https://www.justice.gov/usao-ma/pr/cvs-pay-35-million-resolve-allegations-pharmacists-filled-fake-prescriptions>.

25       <sup>173</sup> Press Release, U.S. Attorney’s Office Dist. of R.I., Drug Diversion Claims  
 26 Against CVS Health Corp. Resolved With \$450,000 Civil Settlement, U.S. Dep’t of  
 27 Just. (Aug. 10, 2015), <https://www.justice.gov/usao-ri/pr/drug-diversion-claims-against-cvs-health-corp-resolved-450000-civil-settlement>.

28       <sup>174</sup> Press Release, U.S. Attorney’s Office M. Dist. of Fla., United States Reaches  
 29 \$22 Million Settlement Agreement With CVS For Unlawful Distribution of  
 30 Controlled Substances, U.S. Dep’t of Just. (May 13, 2015),  
<https://www.justice.gov/usao-mdfl/pr/united-states-reaches-22-million-settlement-agreement-cvs-unlawful-distribution>.

1           285. In September 2014, CVS agreed to pay \$1.9 million in civil penalties  
 2 to resolve allegations it filled prescriptions written by a doctor whose controlled-  
 3 substance registration had expired.<sup>175</sup>

4           286. In August 2013, CVS was fined \$350,000 by the Oklahoma  
 5 Pharmacy Board for improperly selling prescription narcotics in at least five  
 6 locations in the Oklahoma City metropolitan area.<sup>176</sup>

7           287. Dating back to 2006, CVS retail pharmacies in Oklahoma and  
 8 elsewhere intentionally violated the CSA by filling prescriptions signed by  
 9 prescribers with invalid DEA registration numbers.<sup>177</sup>

10           **ii. Walgreens**

11           288. Walgreens is the second-largest pharmacy store chain in the United  
 12 States behind CVS, with annual revenue of more than \$118 billion. According to  
 13 its website, Walgreens operates more than 8,100 retail locations and filled 990  
 14 million prescriptions on a 30-day adjusted basis in fiscal 2017.

15           289. Walgreens also has been penalized for serious and flagrant violations  
 16 of the CSA. Indeed, Walgreens agreed to the largest settlement in DEA history—  
 17 \$80 million—to resolve allegations that it committed an unprecedented number of  
 18 recordkeeping and dispensing violations of the CSA, including negligently  
 19 allowing controlled substances such as oxycodone and other prescription  
 20 painkillers to be diverted for abuse and illegal black market sales.<sup>178</sup>

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 22           

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<sup>175</sup> Patrick Danner, *H-E-B, CVS Fined Over Prescriptions*, San Antonio Express-  
 23 News (Sept. 5, 2014), <http://www.expressnews.com/business/local/article/H-E-B-CVS-fined-over-prescriptions-5736554.php>.

24           <sup>176</sup> Andrew Knittle, *Oklahoma pharmacy board stays busy, hands out massive fines at times*, NewsOK (May 3, 2015), <http://newsok.com/article/5415840>.

25           <sup>177</sup> Press Release, U.S. Attorney's Office W. Dist. of Okla., CVS to Pay \$11  
 26 Million To Settle Civil Penalty Claims Involving Violations of Controlled  
 27 Substances Act, U.S. Dep't of Just. (Apr. 3, 2013), <https://www.justice.gov/usao-wdok/pr/cvs-pay-11-million-settle-civil-penalty-claims-involving-violations-controlled>.

28           <sup>178</sup> Press Release, U.S. Attorney's Office S. Dist. of Fla., *Walgreens Agrees To Pay A Record Settlement Of \$80 Million For Civil Penalties Under The Controlled Substances Act*, U.S. Dep't of Just. (June 11, 2013), <https://www.justice.gov/usao-south-florida/pr/walgreens-agrees-pay-record-settlement-civil-penalties-under-controlled-substances-act>.

1       290. The settlement resolved investigations into and allegations of CSA  
 2 violations in Florida, New York, Michigan, and Colorado that resulted in the  
 3 diversion of millions of opioids into illicit channels.

4       291. Walgreens' Florida operations at issue in this settlement highlight its  
 5 egregious conduct regarding diversion of prescription opioids. Walgreens' Florida  
 6 pharmacies each allegedly ordered more than one million dosage units of  
 7 oxycodone in 2011—more than ten times the average amount.<sup>179</sup>

8       292. They increased their orders over time, in some cases as much as  
 9 600% in the space of just two years, including, for example, supplying a town of  
 10 3,000 with 285,800 orders of oxycodone in a one-month period. Yet Walgreens  
 11 corporate officers turned a blind eye to these abuses. In fact, corporate attorneys  
 12 at Walgreens suggested, in reviewing the legitimacy of prescriptions coming from  
 13 pain clinics, that “if these are legitimate indicators of inappropriate prescriptions  
 14 perhaps we should consider not documenting our own potential noncompliance,”  
 15 underscoring Walgreens’ attitude that profit outweighed compliance with the CSA  
 16 or the health of communities.<sup>180</sup>

17       293. Defendant Walgreens’ settlement with the DEA stemmed from the  
 18 DEA’s investigation into Walgreens’ distribution center in Jupiter, Florida, which  
 19 was responsible for significant opioid diversion in Florida. According to the Order  
 20 to Show Cause, Defendant Walgreens’ corporate headquarters pushed to increase  
 21 the number of oxycodone sales to Walgreens’ Florida pharmacies, and provided  
 22 bonuses for pharmacy employees based on number of prescriptions filled at the  
 23 pharmacy in an effort to increase oxycodone sales. In July 2010, Defendant  
 24

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25  
 26       sdfl/pr/walgreens-agrees-pay-record-settlement-80-million-civil-penalties-under-  
 27 controlled.

28       <sup>179</sup> Order to Show Cause and Immediate Suspension of Registration, *In the Matter of Walgreens Co.* (Drug Enf’t Admin. Sept. 13, 2012).

<sup>180</sup> *Id.*

1 Walgreens ranked all of its Florida stores by number of oxycodone prescriptions  
2 dispensed in June of that year, and found that the highest-ranking store in  
3 oxycodone sales sold almost 18 oxycodone prescriptions per day. All of these  
4 prescriptions were filled by the Jupiter Center.<sup>181</sup>

5 294. Walgreens has also settled with a number of state attorneys general,  
6 including West Virginia (\$575,000) and Massachusetts (\$200,000).<sup>182</sup>

7 295. The Massachusetts Attorney General's Medicaid Fraud Division  
8 found that, from 2010 through most of 2015, multiple Walgreens stores across the  
9 state failed to monitor the opioid use of some Medicaid patients who were  
10 considered high-risk.

11 296. In January 2017, an investigation by the Massachusetts Attorney  
12 General found that some Walgreens pharmacies failed to monitor patients' drug  
13 use patterns and didn't use sound professional judgment when dispensing opioids  
14 and other controlled substances—despite the context of soaring overdose deaths in  
15 Massachusetts. Walgreens agreed to pay \$200,000 and follow certain procedures  
16 for dispensing opioids.<sup>183</sup>

17                   **iii. Rite Aid**

18 297. With approximately 4,600 stores in 31 states and the District of  
19 Columbia, Rite Aid is the largest drugstore chain on the East Coast and the third-  
20 largest in the United States, with annual revenue of more than \$21 billion.

21 298. In 2009, as a result of a multi-jurisdictional investigation by the DOJ,  
22 Rite Aid and nine of its subsidiaries in eight states were fined \$5 million in civil  
23 penalties for its violations of the CSA.<sup>184</sup>

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24  
25                   <sup>181</sup> *Id.*

26                   <sup>182</sup> *Walgreens to pay \$200,000 settlement for lapses with opioids*, APhA (Jan. 25,  
27 2017), <https://www.pharmacist.com/article/walgreens-pay-200000-settlement-lapses-opioids>.

28                   <sup>183</sup> *Id.*

29                   <sup>184</sup> Press Release, Dep't of Just., *Rite Aid Corporation and Subsidiaries Agree to Pay \$5 Million in Civil Penalties to Resolve Violations in Eight States of the*

1        299. The investigation revealed that from 2004 onwards, Rite Aid  
2 pharmacies across the country had a pattern of non-compliance with the  
3 requirements of the CSA and federal regulations that led to the diversion of  
4 prescription opioids in and around the communities of the Rite Aid pharmacies  
5 investigated. Rite Aid also failed to notify the DEA of losses of controlled  
6 substances in violation of 21 USC 842(a)(5) and 21 C.F.R 1301.76(b).<sup>185</sup>

7       300. Numerous state and federal drug diversion prosecutions have  
8 occurred in which prescription opioid pills were procured from National Retail  
9 Pharmacies. The allegations in this Complaint do not attempt to identify all these  
10 prosecutions, and the information above is merely by way of example.

301. The litany of state and federal actions against the National Retail  
Pharmacies demonstrate that they routinely, and as a matter of standard operating  
procedure, violated their legal obligations under the CSA and other laws and  
regulations that govern the distribution and dispensing of prescription opioids.

302. Throughout the country and the State, the National Retail Pharmacies  
were or should have been aware of numerous red flags of potential suspicious  
activity and diversion.

18        303. On information and belief, from the catbird seat of their retail  
19        pharmacy operations, the National Retail Pharmacies knew or reasonably should  
20        have known about the disproportionate flow of opioids into California and the  
21        operation of “pill mills” that generated opioid prescriptions that, by their quantity  
22        or nature, were red flags for if not direct evidence of illicit supply and diversion.  
23        Additional information was provided by news reports, and state and federal  
24        regulatory actions, including prosecutions of pill mills in the area.

<sup>27</sup> *Controlled Substances Act*, U.S. Dep’t of Just. (Jan. 12, 2009),  
<sup>28</sup> <https://www.justice.gov/opa/pr/rite-aid-corporation-and-subsidiaries-agree-pay-5-million-civil-penalties-resolve-violations>.

28 | 185 *Id.*

1       304. On information and belief, the National Retail Pharmacies knew or  
2 reasonably should have known about the devastating consequences of the  
3 oversupply and diversion of prescription opioids, including spiking opioid  
4 overdose rates in the community.

5       305. On information and belief, because of (among others sources of  
6 information) regulatory and other actions taken against the National Retail  
7 Pharmacies directly, actions taken against others pertaining to prescription opioids  
8 obtained from their retail stores, complaints and information from employees and  
9 other agents, and the massive volume of opioid prescription drug sale data that  
10 they developed and monitored, the National Retail Pharmacies were well aware  
11 that their distribution and dispensing activities fell far short of legal requirements.

12       306. The National Retail Pharmacies' actions and omission in failing to  
13 effectively prevent diversion and failing to monitor, report, and prevent suspicious  
14 orders have contributed significantly to the opioid crisis by enabling, and failing  
15 to prevent, the diversion of opioids.

16       **D. THE MANUFACTURER DEFENDANTS' UNLAWFUL FAILURE**  
17       **TO PREVENT DIVERSION AND MONITOR, REPORT, AND**  
18       **PREVENT SUSPICIOUS ORDERS.**

19       307. The same legal duties to prevent diversion, and to monitor, report,  
20 and prevent suspicious orders of prescription opioids that were incumbent upon  
21 the Distributor Defendants were also legally required of the Manufacturer  
22 Defendants under federal law.

23       308. Under federal law, the Manufacturing Defendants were required to  
24 comply with the same licensing requirements and with the same rules regarding  
25 prevention of diversion and reporting suspicious orders, as set out above.

26       309. Like the Distributor Defendants, the Manufacturer Defendants were  
27 required to register with the DEA to manufacture schedule II controlled  
28

1 substances, like prescription opioids. *See* 21 U.S.C. § 823(a). A requirement of  
 2 such registration is the:

3 maintenance of effective controls against diversion of particular  
 4 controlled substances and any controlled substance in schedule I or II  
 5 compounded therefrom into other than legitimate medical, scientific,  
 6 research, or industrial channels, by limiting the importation and bulk  
 7 manufacture of such controlled substances to a number of  
 establishments which can produce an adequate and uninterrupted  
 supply of these substances under adequately competitive conditions  
 for legitimate medical, scientific, research, and industrial purposes . . .  
 .

8 21 U.S.C. § 823(a)(1) (emphasis added).

9 310. Additionally, as “registrants” under Section 823, the Manufacturer  
 10 Defendants were also required to monitor, report, and prevent suspicious orders of  
 11 controlled substances:

12 The registrant shall design and operate a system to disclose to the  
 13 registrant suspicious orders of controlled substances. The registrant  
 14 shall inform the Field Division Office of the Administration in his  
 area of suspicious orders when discovered by the registrant.  
 Suspicious orders include orders of unusual size, orders deviating  
 substantially from a normal pattern, and orders of unusual frequency.

15 21 C.F.R. § 1301.74. *See also* 21 C.F.R. § 1301.02 (“Any term used in this part  
 16 shall have the definition set forth in section 102 of the Act (21 U.S.C. 802) or part  
 17 1300 of this chapter.”); 21 C.F.R. § 1300.01 (“Registrant means any person who is  
 18 registered pursuant to either section 303 or section 1008 of the Act (21 U.S.C. 823  
 19 or 958).” Like the Distributor Defendants, the Manufacture Defendants breached  
 20 these duties.

21 311. The Manufacturer Defendants had access to and possession of the  
 22 information necessary to monitor, report, and prevent suspicious orders and to  
 23 prevent diversion. The Manufacturer Defendants engaged in the practice of  
 24 paying “chargebacks” to opioid distributors. A chargeback is a payment made by  
 25 a manufacturer to a distributor after the distributor sells the manufacturer’s  
 26 product at a price below a specified rate. After a distributor sells a manufacturer’s  
 27 product to a pharmacy, for example, the distributor requests a chargeback from the  
 28 manufacturer and, in exchange for the payment, the distributor identifies to the

1 manufacturer the product, volume and the pharmacy to which it sold the product.  
 2 Thus, the Manufacturer Defendants knew – just as the Distributor Defendants  
 3 knew – the volume, frequency, and pattern of opioid orders being placed and  
 4 filled. The Manufacturer Defendants built receipt of this information into the  
 5 payment structure for the opioids provided to the opioid distributors.

6       312. Federal statutes and regulations are clear: just like opioid  
 7 distributors, opioid manufacturers are required to “design and operate a system to  
 8 disclose . . . suspicious orders of controlled substances” and to maintain “effective  
 9 controls against diversion.” 21 C.F.R. § 1301.74; 21 U.S.C. § 823(a)(1).

10      313. The Department of Justice has recently confirmed the suspicious  
 11 order obligations clearly imposed by federal law upon opioid manufacturers,  
 12 fining Mallinckrodt \$35 million for failure to report suspicious orders of  
 13 controlled substances, including opioids, and for violating recordkeeping  
 14 requirements.<sup>186</sup>

15      314. In the press release accompanying the settlement, the Department of  
 16 Justice stated: Mallinckrodt “did not meet its obligations to detect and notify DEA  
 17 of suspicious orders of controlled substances such as oxycodone, the abuse of  
 18 which is part of the current opioid epidemic. These suspicious order monitoring  
 19 requirements exist to prevent excessive sales of controlled substances, like  
 20 oxycodone . . . . Mallinckrodt’s actions and omissions formed a link in the chain  
 21 of supply that resulted in millions of oxycodone pills being sold on the street. . . .  
 22 ‘Manufacturers and distributors have a crucial responsibility to ensure that  
 23 controlled substances do not get into the wrong hands. . . .’”<sup>187</sup>

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 26      <sup>186</sup> See Press Release, U.S. Dep’t of Justice, Mallinckrodt Agrees to Pay Record  
 27      \$35 Million Settlement for Failure to Report Suspicious Orders of Pharmaceutical  
 28      Drugs and for Recordkeeping Violations (July 11, 2017),  
<https://www.justice.gov/opa/pr/mallinckrodt-agrees-pay-record-35-million-settlement-failure-report-suspicious-orders>.

29      <sup>187</sup> *Id.* (quoting DEA Acting Administrator Chuck Rosenberg).

1       315. Among the allegations resolved by the settlement, the government  
 2 alleged “Mallinckrodt failed to design and implement an effective system to detect  
 3 and report ‘suspicious orders’ for controlled substances – orders that are unusual  
 4 in their frequency, size, or other patterns . . . [and] Mallinckrodt supplied  
 5 distributors, and the distributors then supplied various U.S. pharmacies and pain  
 6 clinics, an increasingly excessive quantity of oxycodone pills without notifying  
 7 DEA of these suspicious orders.”<sup>188</sup>

8       316. The Memorandum of Agreement entered into by Mallinckrodt  
 9 (“2017 Mallinckrodt MOA”) avers “[a]s a registrant under the CSA, Mallinckrodt  
 10 had a responsibility to maintain effective controls against diversion, including a  
 11 requirement that it review and monitor these sales and report suspicious orders to  
 12 DEA.”<sup>189</sup>

13       317. The 2017 Mallinckrodt MOA further details the DEA’s allegations  
 14 regarding Mallinckrodt’s failures to fulfill its legal duties as an opioid  
 15 manufacturer:

16       With respect to its distribution of oxycodone and hydrocodone  
 17 products, Mallinckrodt’s alleged failure to distribute these controlled  
 18 substances in a manner authorized by its registration and  
 19 Mallinckrodt’s alleged failure to operate an effective suspicious order  
 20 monitoring system and to report suspicious orders to the DEA when  
 21 discovered as required by and in violation of 21 C.F.R. § 1301.74(b).  
 22 The above includes, but is not limited to Mallinckrodt’s alleged failure  
 23 to:  
 24           i. conduct adequate due diligence of its customers;  
 25           ii. detect and report to the DEA orders of unusual size and  
 26           frequency;  
 27           iii. detect and report to the DEA orders deviating substantially  
 28           from normal patterns including, but not limited to, those  
 29           identified in letters from the DEA Deputy Assistant

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26       <sup>188</sup> *Id.*

27       <sup>189</sup> Administrative Memorandum of Agreement between the United States  
 28 Department of Justice, the Drug Enforcement Agency, and Mallinckrodt, plc. and  
 29 its subsidiary Mallinckrodt, LLC (July 10, 2017), <https://www.justice.gov/usao-edmi/press-release/file/986026/download> (“2017 Mallinckrodt MOA”).

Administrator, Office of Diversion Control, to registrants dated September 27, 2006 and December 27, 2007:

- 1           1. orders that resulted in a disproportionate amount of a  
2           substance which is most often abused going to a  
3           particular geographic region where there was known  
4           diversion,
- 5           2. orders that purchased a disproportionate amount of a  
6           substance which is most often abused compared to other  
7           products, and
- 8           3. orders from downstream customers to distributors who  
9           were purchasing from multiple different distributors, of  
10          which Mallinckrodt was aware;
- 11          iv. use "chargeback" information from its distributors to evaluate  
12          suspicious orders. Chargebacks include downstream  
13          purchasing information tied to certain discounts, providing  
14          Mallinckrodt with data on buying patterns for Mallinckrodt  
15          products; and
- 16          v. take sufficient action to prevent recurrence of diversion by  
17          downstream customers after receiving concrete information of  
18          diversion of Mallinckrodt product by those downstream  
19          customers.<sup>190</sup>

20          318. Mallinckrodt agreed that its "system to monitor and detect suspicious  
21          orders did not meet the standards outlined in letters from the DEA Deputy  
22          Administrator, Office of Diversion Control, to registrants dated September 27,  
23          2006 and December 27, 2007." Mallinckrodt further agreed that it "recognizes the  
24          importance of the prevention of diversion of the controlled substances they  
25          manufacture" and would "design and operate a system that meets the requirements  
26          of 21 CFR 1301.74(b) . . . [such that it would] utilize all available transaction  
27          information to identify suspicious orders of any Mallinckrodt product. Further,  
28          Mallinckrodt agrees to notify DEA of any diversion and/or suspicious  
circumstances involving any Mallinckrodt controlled substances that Mallinckrodt  
discovers."<sup>191</sup>

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<sup>190</sup> 2017 Mallinckrodt MOA at 2-3.

<sup>191</sup> *Id.* at 3-4.

1       319. Mallinckrodt acknowledged that “[a]s part of their business model  
2 Mallinckrodt collects transaction information, referred to as chargeback data, from  
3 their direct customers (distributors). The transaction information contains data  
4 relating to the direct customer sales of controlled substances to ‘downstream’  
5 registrants.” Mallinckrodt agreed that, from this data, it would “report to the DEA  
6 when Mallinckrodt concludes that the chargeback data or other information  
7 indicates that a downstream registrant poses a risk of diversion.”<sup>192</sup>

8       320. The same duties imposed by federal law on Mallinckrodt were  
9 imposed upon all Manufacturer Defendants.

10      321. The same business practices utilized by Mallinckrodt regarding  
11 “charge backs” and receipt and review of data from opioid distributors regarding  
12 orders of opioids were utilized industry-wide among opioid manufacturers and  
13 distributors, including, upon information and belief, the other Manufacturer  
14 Defendants.

15      322. Through, *inter alia*, the charge back data, the Manufacturer  
16 Defendants could monitor suspicious orders of opioids.

17      323. The Manufacturer Defendants failed to monitor, report, and halt  
18 suspicious orders of opioids as required by federal and state law.

19      324. The Manufacturer Defendants’ failures to monitor, report, and halt  
20 suspicious orders of opioids were intentional and unlawful.

21      325. The Manufacturer Defendants have misrepresented their compliance  
22 with federal and state law.

23      326. The Manufacturer Defendants enabled the supply of prescription  
24 opioids to obviously suspicious physicians and pharmacies, enabled the illegal  
25 diversion of opioids, aided criminal activity, and disseminated massive quantities  
26 of prescription opioids into the black market.

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<sup>192</sup> *Id.* at 5.

1           327. The wrongful actions and omissions of the Manufacturer Defendants  
 2 which have caused the diversion of opioids and which have been a substantial  
 3 contributing factor to and/or proximate cause of the opioid crisis are alleged in  
 4 greater detail in the racketeering allegations below.

5           328. The Manufacturer Defendants' actions and omissions in failing to  
 6 effectively prevent diversion and failing to monitor, report, and prevent suspicious  
 7 orders have enabled the unlawful diversion of opioids into Plaintiffs' Community.

8           **E. DEFENDANTS' UNLAWFUL CONDUCT AND BREACHES OF  
 9           LEGAL DUTIES CAUSED THE HARM ALLEGED HEREIN AND  
 10          SUBSTANTIAL DAMAGES.**

11          329. As the Manufacturer Defendants' efforts to expand the market for  
 12 opioids increased so have the rates of prescription and sale of their products —  
 13 and the rates of opioid-related substance abuse, hospitalization, and death among  
 14 the people of the State and the Plaintiffs' Community. The Distributor Defendants  
 15 have continued to unlawfully ship these massive quantities of opioids into  
 16 communities like the Plaintiffs' Community, fueling the epidemic.

17          330. There is a "parallel relationship between the availability of  
 18 prescription opioid analgesics through legitimate pharmacy channels and the  
 19 diversion and abuse of these drugs and associated adverse outcomes."<sup>193</sup>

20          331. Opioid analgesics are widely diverted and improperly used, and the  
 21 widespread use of the drugs has resulted in a national epidemic of opioid overdose  
 22 deaths and addictions.<sup>194</sup>

23          332. The epidemic is "directly related to the increasingly widespread  
 24 misuse of powerful opioid pain medications."<sup>195</sup>

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<sup>193</sup> See Richard C. Dart et al., Trends in Opioid Analgesic Abuse and Mortality in  
 the United States, 372 N. Eng. J. Med. 241 (2015).

28          <sup>194</sup> See Nora D. Volkow & A. Thomas McLellan, *Opioid Abuse in Chronic Pain—  
 Misconceptions and Mitigation Strategies*, 374 N. Eng. J. Med. 1253 (2016).

1           333. The increased abuse of prescription painkillers along with growing  
 2 sales has contributed to a large number of overdoses and deaths.<sup>196</sup>

3           334. As shown above, the opioid epidemic has escalated in Plaintiffs'  
 4 Community with devastating effects. Substantial opiate-related substance abuse,  
 5 hospitalization and death mirrors Defendants' increased distribution of opiates.

6           335. Because of the well-established relationship between the use of  
 7 prescription opiates and the use of non-prescription opioids, like heroin, the  
 8 massive distribution of opioids to Plaintiffs' Community and areas from which  
 9 such opioids are being diverted into Plaintiffs' Community, has caused the  
 10 Defendant-caused opioid epidemic to include heroin addiction, abuse, and death.

11          336. Prescription opioid abuse, addiction, morbidity, and mortality are  
 12 hazards to public health and safety in the State and in Plaintiffs' Community.

13          337. Heroin abuse, addiction, morbidity, and mortality are hazards to  
 14 public health and safety in the State and in Plaintiffs' Community.

15          338. Defendants repeatedly and purposefully breached their duties under  
 16 state and federal law, and such breaches are direct and proximate causes of, and/or  
 17 substantial factors leading to, the widespread diversion of prescription opioids for  
 18 nonmedical purposes into the Plaintiffs' Community.

19          339. The unlawful diversion of prescription opioids is a direct and  
 20 proximate cause of, and/or substantial factor leading to, the opioid epidemic,  
 21 prescription opioid abuse, addiction, morbidity and mortality in the State and  
 22 Plaintiffs' Community. This diversion and the epidemic are direct causes of  
 23 foreseeable harms incurred by the Plaintiffs and Plaintiffs' Community.

24  
 25  
 26<sup>195</sup> See Robert M. Califf et al., *A Proactive Response to Prescription Opioid Abuse*,  
 374 N. Eng. J. Med. 1480 (2016).

27<sup>196</sup> See Press Release, Ctrs. for Disease Control and Prevention, U.S. Dep't of  
 28 Health and Human Servs., Prescription Painkiller Overdoses at Epidemic Levels  
 (Nov. 1, 2011),  
[https://www.cdc.gov/media/releases/2011/p1101\\_flu\\_pain\\_killer\\_overdose.html](https://www.cdc.gov/media/releases/2011/p1101_flu_pain_killer_overdose.html).

1       340. Defendants' intentional and/or unlawful conduct resulted in direct  
2 and foreseeable, past and continuing, economic damages for which Plaintiffs seek  
3 relief, as alleged herein. Plaintiffs also seek the means to abate the epidemic  
4 created by Defendants' wrongful and/or unlawful conduct.

5       341. The County seeks economic damages from the Defendants as  
6 reimbursement for the costs associated with damage to its property and past  
7 efforts to eliminate the hazards to public health and safety.

8       342. Plaintiffs seek economic damages from the Defendants to pay for the  
9 cost to permanently eliminate the hazards to public health and safety and abate the  
10 temporary public nuisance.

11       343. To eliminate the hazard to public health and safety, and abate the  
12 public nuisance, a "multifaceted, collaborative public health and law enforcement  
13 approach is urgently needed."<sup>197</sup>

14       344. A comprehensive response to this crisis must focus on preventing  
15 new cases of opioid addiction, identifying early opioid-addicted individuals, and  
16 ensuring access to effective opioid addiction treatment while safely meeting the  
17 needs of patients experiencing pain.<sup>198</sup>

18       345. These community-based problems require community-based  
19 solutions that have been limited by "budgetary constraints at the state and Federal  
20 levels."<sup>199</sup>

21  
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23       

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<sup>197</sup> See Rose A. Rudd et al., *Increases in Drug and Opioid Overdose Deaths—United States, 2000–2014*, 64 Morbidity & Mortality Wkly. Rep. 1378 (2016), at 1145.

24  
25       <sup>198</sup> See Johns Hopkins Bloomberg School of Public Health, *The Prescription Opioid Epidemic: An Evidence-Based Approach* (G. Caleb Alexander et al. eds., 2015), [http://www.jhsph.edu/research/centers-and-institutes/center-for-drug-safety-and-effectiveness/research/prescription-opioids/JHSPH\\_OPIOID\\_EPIDEMIC\\_REPORT.pdf](http://www.jhsph.edu/research/centers-and-institutes/center-for-drug-safety-and-effectiveness/research/prescription-opioids/JHSPH_OPIOID_EPIDEMIC_REPORT.pdf).

26  
27       <sup>199</sup> See Office of Nat'l Drug Control Policy, Exec. Office of the President, *Epidemic: Responding to America's Prescription Drug Abuse Crisis* (2011), [https://www.ncjrs.gov/pdffiles1/ondcp/rx\\_abuse\\_plan.pdf](https://www.ncjrs.gov/pdffiles1/ondcp/rx_abuse_plan.pdf).

1           346. Having profited enormously through the aggressive sale, misleading  
2 promotion, and irresponsible distribution of opiates, Defendants should be  
3 required to take responsibility for the financial burdens their conduct has inflicted  
4 upon the Plaintiffs and Plaintiffs' Community.

5           **F. STATUTES OF LIMITATIONS ARE TOLLED AND DEFENDANTS  
6           ARE ESTOPPED FROM ASSERTING STATUTES OF  
7           LIMITATIONS AS DEFENSES.**

8           **1. Enforcement of a Public Right.**

9           347. No statute of limitation can be pleaded against the Plaintiffs, which  
10 seek to enforce strictly public rights.

11           **2. Continuing Conduct.**

12           348. Plaintiffs contend they continue to suffer harm from the unlawful  
13 actions by the Defendants.

14           349. The continued tortious and unlawful conduct by the Defendants  
15 causes a repeated or continuous injury. The damages have not occurred all at  
16 once but have continued to occur and have increased as time progresses. The tort  
17 is not completed nor have all the damages been incurred until the wrongdoing  
18 ceases. The wrongdoing and unlawful activity by Defendants has not ceased. The  
19 public nuisance remains unabated. The conduct causing the damages remains  
20 unabated.

21           **3. Equitable Estoppel.**

22           350. To the extent any statute of limitations defense would apply,  
23 Defendants are equitably estopped from relying upon a statute of limitations  
24 defense because they undertook active efforts to deceive Plaintiffs and to  
25 purposefully conceal their unlawful conduct and fraudulently assure the public,  
26 including the State, the Plaintiffs, and Plaintiffs' Community, that they were  
27 undertaking efforts to comply with their obligations under the state and federal  
28 controlled substances laws, all with the goal of protecting their registered

1 manufacturer or distributor status in the State and to continue generating profits.  
 2 Notwithstanding the allegations set forth above, the Defendants affirmatively  
 3 assured the public, including the State, the Plaintiffs, and Plaintiffs' Community,  
 4 that they are working to curb the opioid epidemic.

5       351. For example, a Cardinal Health executive claimed that it uses  
 6 "advanced analytics" to monitor its supply chain, and assured the public it was  
 7 being "as effective and efficient as possible in constantly monitoring, identifying,  
 8 and eliminating any outside criminal activity."<sup>200</sup>

9       352. Similarly, McKesson publicly stated that it has a "best-in-class  
 10 controlled substance monitoring program to help identify suspicious orders," and  
 11 claimed it is "deeply passionate about curbing the opioid epidemic in our  
 12 country."<sup>201</sup>

13       353. Moreover, in furtherance of their effort to affirmatively conceal their  
 14 conduct and avoid detection, the Distributor Defendants, through their trade  
 15 associations, HDMA and NACDS, filed an *amicus* brief in *Masters*  
 16 *Pharmaceuticals*, which made the following statements:<sup>202</sup>

- 17       a. "HDMA and NACDS members not only have statutory and  
       regulatory responsibilities to guard against diversion of controlled  
       prescription drugs, but undertake such efforts as responsible  
       members of society."
- 18       b. "DEA regulations that have been in place for more than 40 years  
       require distributors to *report* suspicious orders of controlled  
       substances to DEA based on information readily available to them  
       (e.g., a pharmacy's placement of unusually frequent or large orders)."
- 19       c. "Distributors take seriously their duty to report suspicious orders,  
       utilizing both computer algorithms and human review to detect

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24  
 25       <sup>200</sup> Bernstein et al., *supra*.

26       <sup>201</sup> Scott Higham et al., *Drug Industry Hired Dozens of Officials from the DEA as*  
 27 *the Agency Tried to Curb Opioid Abuse*, Wash. Post, Dec. 22, 2016,  
 28 [https://www.washingtonpost.com/investigations/key-officials-switch-sides-from-dea-to-pharmaceutical-industry/2016/12/22/55d2e938-c07b-11e6-b527-949c5893595e\\_story.html](https://www.washingtonpost.com/investigations/key-officials-switch-sides-from-dea-to-pharmaceutical-industry/2016/12/22/55d2e938-c07b-11e6-b527-949c5893595e_story.html).

29       <sup>202</sup> Brief for HDMA and NACDS, 2016 WL 1321983, at \*3-4, \*25.

1                   suspicious orders based on the generalized information that *is*  
2                   available to them in the ordering process.”

3                   d. “A particular order or series of orders can raise red flags because of  
4                   its unusual size, frequency, or departure from typical patterns with a  
5                   given pharmacy.”

6                   e. “Distributors also monitor for and report abnormal behavior by  
7                   pharmacies placing orders, such as refusing to provide business  
8                   contact information or insisting on paying in cash.”

9                   Through the above statements made on their behalf by their trade associations,  
10                  and other similar statements assuring their continued compliance with their legal  
11                  obligations, the Distributor Defendants not only acknowledged that they  
12                  understood their obligations under the law, but they further affirmed that their  
13                  conduct was in compliance with those obligations.

14                  354. The Distributor Defendants have also concealed and prevented  
15                  discovery of information, including data from the ARCOS database that will  
16                  confirm their identities and the extent of their wrongful and illegal activities.

17                  355. The Manufacturer Defendants distorted the meaning or import of  
18                  studies they cited and offered them as evidence for propositions the studies did not  
19                  support. The Manufacturer Defendants invented “pseudoaddiction” and promoted  
20                  it to an unsuspecting medical community. The Manufacturer Defendants provided  
21                  the medical community with false and misleading information about ineffectual  
22                  strategies to avoid or control opioid addiction. The Manufacturer Defendants recommended  
23                  to the medical community that dosages be increased, without  
24                  disclosing the risks. The Manufacturer Defendants spent millions of dollars over a  
25                  period of years on a misinformation campaign aimed at highlighting opioids’  
26                  alleged benefits, disguising the risks, and promoting sales. The medical  
27                  community, consumers, the State, and Plaintiffs’ Community were duped by the  
28                  Manufacturer Defendants’ campaign to misrepresent and conceal the truth about  
                        the opioid drugs that they were aggressively pushing in the State and in Plaintiffs’  
                        Community.

1       356. Defendants intended that their actions and omissions would be relied  
2 upon, including by Plaintiffs and Plaintiffs' Community. Plaintiffs and Plaintiffs'  
3 Community did not know, and did not have the means to know, the truth due to  
4 Defendants' actions and omissions.

5       357. The Plaintiffs and Plaintiffs' Community reasonably relied on  
6 Defendants' affirmative statements regarding their purported compliance with  
7 their obligations under the law and consent orders. To the extent statutes of  
8 limitations could apply to Plaintiffs' claims, Plaintiffs failed to commence an  
9 action within the statutory periods because of reliance on Defendants' wrongful  
10 conduct.

11       358. Defendants are estopped from asserting a statute of limitations  
12 defense because their conduct and misrepresentations were so unfair and  
13 misleading as to outweigh the public's interest in setting limitations on bringing  
14 actions.

15       **4. Fraudulent Concealment**

16       359. To the extent any statute of limitations defense would apply,  
17 Plaintiffs' claims are further subject to equitable tolling, stemming from  
18 Defendants' knowing and fraudulent concealment of the facts alleged herein. As  
19 alleged herein, Defendants knew of the wrongful acts set forth above, had material  
20 information pertinent to their discovery, and concealed them from the Plaintiffs  
21 and Plaintiffs' Community. The Plaintiffs did not know, or could not have known  
22 through the exercise of reasonable diligence, of their causes of action, as a result  
23 of Defendants' conduct.

24       360. The purposes of the statutes of limitations period, if any, are satisfied  
25 because Defendants cannot claim prejudice due to a late filing where the Plaintiffs  
26 filed suit promptly upon discovering the facts essential to their claims, described  
27 herein, which Defendants knowingly concealed.

28

1       361. In light of their statements to the media, in legal filings and in  
2 settlements, it is clear that Defendants had actual or constructive knowledge that  
3 their conduct was deceptive, in that they consciously concealed the schemes set  
4 forth herein.

5       362. Defendants continually and secretly engaged in their scheme to avoid  
6 compliance with their legal obligations. Only Defendants and their agents knew or  
7 could have known about Defendants' unlawful actions because Defendants made  
8 deliberate efforts to conceal their conduct. As a result of the above, the Plaintiffs  
9 were unable to obtain vital information bearing on their claims absent any fault or  
10 lack of diligence on their part.

## **V. LEGAL CAUSES OF ACTION**

## COUNT I

## PUBLIC NUISANCE

## **(Brought by The People Against all Defendants)**

15       363. Plaintiff, The People, incorporate by reference all other paragraphs of  
16 this Complaint as if fully set forth here, and further allege as follows.

17       364. Each Defendant is liable for public nuisance because its conduct at  
18 issue has caused an unreasonable and substantial interference with a right  
19 common to the general public. *See Cty. of Santa Clara v. Atl. Richfield Co.*, 137  
20 Cal. App. 4th 292, 305, 40 Cal. Rptr. 3d 313, 325 (2006) (cit. om.). The  
21 interference is substantial “if it causes significant harm and unreasonable if its  
22 social utility is outweighed by the gravity of the harm inflicted.” *Id.* The causation  
23 element of a public nuisance cause of action is satisfied if the defendant’s conduct  
24 is a substantial factor in bringing about the result. *People v. Conagra Grocery*  
25 *Prod. Co.*, 17 Cal. App. 5th 51, 101-02, 227 Cal. Rptr. 3d 499, 543 (Ct. App.  
26 2017), *reh’g denied* (Dec. 6, 2017), *review denied* (Feb. 14, 2018).

365. Under California law, a nuisance is “anything which is injurious to  
health, including but not limited to the illegal sale of controlled substances, or is

1 indecent or offensive to the senses, or an obstruction to the free use of property, so  
2 as to interfere with the comfortable enjoyment of life or property.” Cal. Civ. Code  
3 § 3479.

4       366. California defines a “public nuisance” as “one which affects at the  
5 same time an entire community or neighborhood, or any considerable number of  
6 persons, although the extent of the annoyance or damage inflicted upon  
7 individuals may be unequal.” Cal. Civ. Code § 3480.

8       367. Defendants have created a public nuisance under California law.

9       368. The People have standing to bring this claim to abate the public  
10 nuisance due to the opioid epidemic which was created by Defendants and which  
11 is affecting and causing harm in Plaintiffs’ Community. *See* Cal. Civ. Proc. Code  
12 § 731.

13       369. By causing dangerously addictive drugs to flood the community, and  
14 to be diverted for illicit purposes, in contravention of federal and state law, each  
15 Defendant has injuriously affected rights common to the general public,  
16 specifically including the rights of the people of the Plaintiffs’ Community to  
17 public health, public safety, public peace, public comfort, and public convenience.  
18 The public nuisance caused by Defendants’ diversion of dangerous drugs has  
19 caused substantial annoyance, inconvenience, and injury to the public.

20       370. By selling dangerously addictive opioid drugs diverted from a  
21 legitimate medical, scientific, or industrial purpose, Defendants have committed a  
22 course of conduct that injuriously affects the safety, health, and morals of the  
23 people of the Plaintiffs’ Community.

24       371. By failing to maintain a closed system that guards against diversion  
25 of dangerously addictive drugs for illicit purposes, Defendants injuriously affected  
26 public rights, including the right to public health, public safety, public peace, and  
27 public comfort of the people of the Plaintiffs’ Community.

28

1       372. By affirmatively promoting opioids for use for chronic pain,  
2 affirmatively promoting opioids as not addictive, affirmatively fostering a  
3 misunderstanding of the signs of addiction and how to reliably identify and safely  
4 prescribe opioids to patients predisposed to addiction, affirmatively exaggerating  
5 the risks of competing medications like NSAIDs, affirmatively promoting their  
6 so-called abuse-deterring opioid formulations and affirmatively identifying and  
7 targeting susceptible prescribers and vulnerable patient populations, Defendants  
8 injuriously affected public rights, including the right to public health, public  
9 safety, public peace, and public comfort of the people of the Plaintiffs'  
10 Community. The public nuisance caused by Defendants' affirmative promotion  
11 of opioids has caused substantial annoyance, inconvenience, and injury to the  
12 public.

13       373. Defendants' interference with the comfortable enjoyment of life in  
14 the Plaintiffs' Community is unreasonable because there is little social utility to  
15 opioid diversion and abuse, and any potential value is outweighed by the gravity  
16 of the harm inflicted by Defendants' actions.

17       374. The People allege that Defendants' wrongful and illegal actions have  
18 created a public nuisance. Each Defendant is liable for public nuisance because its  
19 conduct at issue has caused an unreasonable and substantial interference with a  
20 right common to the general public.

21       375. The Defendants have intentionally and/or unlawfully created a  
22 nuisance.

23       376. The residents of Plaintiffs' Community have a common right to be  
24 free from conduct that creates an unreasonable jeopardy to the public health,  
25 welfare and safety, and to be free from conduct that creates a disturbance and  
26 reasonable apprehension of danger to person and property.

27       377. Defendants intentionally, unlawfully, and recklessly manufacture,  
28 market, distribute, promote and sell prescription opioids that Defendants know, or

1 reasonably should know, will be diverted, causing widespread distribution of  
2 prescription opioids in and/or to Plaintiffs' Community, resulting in addiction and  
3 abuse, an elevated level of crime, death and injuries to the residents of Plaintiffs'  
4 Community, a higher level of fear, discomfort and inconvenience to the residents  
5 of Plaintiffs' Community, and direct costs to Plaintiffs' Community.

6       378. Defendants have unlawfully and/or intentionally caused and  
7 permitted dangerous drugs under their control to be diverted such as to injure the  
8 Plaintiffs' Community and its residents.

9       379. Defendants have unlawfully and/or intentionally promoted and  
10 distributed opioids or caused opioids to be distributed without maintaining  
11 effective controls against diversion. Such conduct was illegal. Defendants'  
12 failures to maintain effective controls against diversion include Defendants'  
13 failure to effectively monitor for suspicious orders, report suspicious orders,  
14 and/or stop shipment of suspicious orders.

15       380. Defendants have caused a significant and unreasonable interference  
16 with the public health, safety, welfare, peace, comfort and convenience, and  
17 ability to be free from disturbance and reasonable apprehension of danger to  
18 person or property.

19       381. Defendants' conduct in illegally distributing and selling prescription  
20 opioids, or causing such opioids to be distributed and sold, where Defendants  
21 know, or reasonably should know, such opioids will be diverted and possessed  
22 and/or used illegally in Plaintiffs' Community is of a continuing nature.

23       382. Defendants' actions have been of a continuing nature and have  
24 produced a significant effect upon the public's rights, including the public's right  
25 to health and safety.

26       383. A violation of any rule or law controlling the distribution of a drug of  
27 abuse in Plaintiffs' Community and the State is a public nuisance.

28

1       384. Defendants' distribution of opioids while failing to maintain effective  
2 controls against diversion was proscribed by statute and regulation.

3       385. Defendants' ongoing conduct produces an ongoing nuisance, as the  
4 prescription opioids that they allow and/or cause to be illegally distributed and  
5 possessed in Plaintiffs' Community will be diverted, leading to abuse, addiction,  
6 crime, and public health costs.

7       386. Because of the continued use and addiction caused by these illegally  
8 distributed opioids, The People will continue to fear for their health, safety and  
9 welfare, and will be subjected to conduct that creates a disturbance and reasonable  
10 apprehension of danger to person and property.

11       387. Defendants know, or reasonably should know, that their conduct will  
12 have an ongoing detrimental effect upon the public health, safety and welfare, and  
13 the public's ability to be free from disturbance and reasonable apprehension of  
14 danger to person and property.

15       388. Defendants know, or reasonably should know, that their conduct  
16 causes an unreasonable and substantial invasion of the public right to health,  
17 safety and welfare and the public's ability to be free from disturbance and  
18 reasonable apprehension of danger to person and property.

19       389. Defendants are aware, and at a bare minimum certainly should be  
20 aware, of the unreasonable interference that their conduct has caused in Plaintiffs'  
21 Community. Defendants are in the business of manufacturing, marketing, selling,  
22 and distributing prescription drugs, including opioids, which are specifically  
23 known to Defendants to be dangerous because *inter alia* these drugs are defined  
24 under federal and state law as substances posing a high potential for abuse and  
25 severe addiction. *See, e.g.,* 21 U.S.C. § 812 (b)(2). Defendants created an  
26 intentional nuisance. Defendants' actions created and expanded the abuse of  
27 opioids, drugs specifically codified as constituting severely harmful substances.

28

1       390. Defendants' conduct in promoting, marketing, distributing, and  
2 selling prescription opioids which the Defendants know, or reasonably should  
3 know, will likely be diverted for non-legitimate, non-medical use, creates a strong  
4 likelihood that these illegal distributions of opioids will cause death and injuries to  
5 residents in Plaintiffs' Community and otherwise significantly and unreasonably  
6 interfere with public health, safety and welfare, and with The People's right to be  
7 free from disturbance and reasonable apprehension of danger to person and  
8 property.

9       391. It is, or should be, reasonably foreseeable to defendants that their  
10 conduct will cause deaths and injuries to residents in Plaintiffs' Community, and  
11 will otherwise significantly and unreasonably interfere with public health, safety  
12 and welfare, and with the public's right to be free from disturbance and reasonable  
13 apprehension of danger to person and property.

14       392. The prevalence and availability of diverted prescription opioids in the  
15 hands of irresponsible persons and persons with criminal purposes in Plaintiffs'  
16 Community not only causes deaths and injuries, but also creates a palpable  
17 climate of fear among residents in Plaintiffs' Community where opioid diversion,  
18 abuse, addiction are prevalent and where diverted opioids tend to be used  
19 frequently.

20       393. Defendants' conduct makes it easier for persons to divert prescription  
21 opioids, constituting a dangerous threat to the public.

22       394. Defendants' actions were, at the least, a substantial factor in opioids  
23 becoming widely available and widely used for non-medical purposes. Because of  
24 Defendants' affirmative promotion of opioids and special positions within the  
25 closed system of opioid distribution, without Defendants' actions, opioid use  
26 would not have become so widespread, and the enormous public health hazard of  
27 prescription opioid and heroin overuse, abuse, and addiction that now exists  
28 would have been averted.

1       395. The presence of diverted prescription opioids in Plaintiffs' 2 Community, and the consequence of prescription opioids having been diverted in 3 Plaintiffs' Community, proximately results in and/or substantially contributes to 4 the creation of significant future costs to The People and to Plaintiffs' Community 5 in order to enforce the law, equip its police force and treat the victims of opioid 6 abuse and addiction.

7       396. Stemming the flow of illegally distributed prescription opioids, and 8 abating the nuisance caused by the illegal flow of opioids, will help to alleviate 9 this problem, save lives, prevent injuries and make Plaintiffs' Community a safer 10 place to live.

11       397. Defendants' conduct is a direct and proximate cause of and/or a 12 substantial contributing factor to opioid addiction and abuse in Plaintiffs' 13 Community, costs that will be borne by Plaintiffs' Community and The People, 14 and a significant and unreasonable interference with public health, safety and 15 welfare, and with the public's right to be free from disturbance and reasonable 16 apprehension of danger to person and property.

17       398. Defendants' conduct constitutes a public nuisance and, if unabated, 18 will continue to threaten the health, safety and welfare of the residents of 19 Plaintiffs' Community, creating an atmosphere of fear and addiction that tears at 20 the residents' sense of well-being and security. The People have a clearly 21 ascertainable right to prospectively abate conduct that perpetuates this nuisance.

22       399. Defendants created an intentional nuisance. Defendants' actions 23 created and expanded the abuse of opioids, which are dangerously addictive, and 24 the ensuing associated plague of prescription opioid and heroin addiction. 25 Defendants knew the dangers to public health and safety that diversion of opioids 26 would create in Plaintiffs' Community; however, Defendants intentionally and/or 27 unlawfully failed to maintain effective controls against diversion through proper 28 monitoring, reporting and refusal to fill suspicious orders of opioids. Defendants

1 intentionally and/or unlawfully distributed opioids or caused opioids to be  
2 distributed without reporting or refusing to fill suspicious orders or taking other  
3 measures to maintain effective controls against diversion. Defendants  
4 intentionally and/or unlawfully continued to ship and failed to halt suspicious  
5 orders of opioids, or caused such orders to be shipped. Defendants intentionally  
6 and/or unlawfully promoted and marketed opioids in manners they knew to be  
7 false and misleading. Such actions were inherently dangerous.

8       400. Defendants knew the prescription opioids have a high likelihood of  
9 being diverted. It was foreseeable to Defendants that where Defendants distributed  
10 prescription opioids or caused such opioids to be distributed without maintaining  
11 effective controls against diversion, including monitoring, reporting, and refusing  
12 shipment of suspicious orders, that the opioids would be diverted, and create an  
13 opioid abuse nuisance in Plaintiffs' Community.

14       401. Defendants' actions also created a nuisance by acting recklessly,  
15 negligently and/or carelessly, in breach of their duties to maintain effective  
16 controls against diversion, thereby creating an unreasonable and substantial risk of  
17 harm.

18       402. Defendants acted with actual malice because Defendants acted with a  
19 conscious disregard for the rights and safety of other persons, and said actions  
20 have a great probability of causing substantial harm.

21       403. The public nuisance created, perpetuated and maintained by  
22 Defendants can be prospectively abated and further reoccurrence of such harm  
23 and inconvenience can be prevented.

24       404. The People further seek to prospectively abate the nuisance created  
25 by the Defendants' unreasonable, unlawful, intentional, ongoing, continuing,  
26 substantial and persistent actions and omissions and interference with a right  
27 common to the public.

28

1       405. Defendants' intentional and unlawful actions and omissions and  
2 unreasonable interference with a right common to the public are of a continuing  
3 nature.

4       406. The public nuisance created by Defendants' actions is substantial and  
5 unreasonable – it has caused and continues to cause significant harm to the  
6 community, and the harm inflicted outweighs any offsetting benefit. The  
7 staggering rates of opioid and heroin use resulting from the Defendants'  
8 abdication of their gate-keeping and diversion prevention duties, and the  
9 Manufacturer Defendants' fraudulent marketing activities, have caused harm to  
10 the entire community that includes, but is not limited to the following:

- 11           a. The high rates of use leading to unnecessary opioid abuse, addiction,  
12           overdose, injuries, and deaths.
- 13           b. Even children have fallen victim to the opioid epidemic. Easy access  
14           to prescription opioids made opioids a recreational drug of choice  
15           among teenagers. Even infants have been born addicted to opioids  
16           due to prenatal exposure, causing severe withdrawal symptoms and  
17           lasting developmental impacts.
- 18           c. Even those residents of Plaintiffs' Community who have never taken  
19           opioids have suffered from the public nuisance arising from  
20           Defendants' abdication of their gate-keeper duties and fraudulent  
21           promotions. Many residents have endured and will endure both the  
22           emotional and financial costs of caring for loved ones addicted to or  
23           injured by opioids, and the loss of companionship, wages, or other  
24           support from family members who have used, abused, become  
25           addicted to, overdosed on, or been killed by opioids.
- 26           d. The opioid epidemic has increased and will increase health care  
27           costs.
- 28           e. Employers have lost and will continue to lose the value of productive  
29           and healthy employees.
- 30           f. Defendants' conduct created and continues to create an abundance of  
31           drugs available for criminal use and fueled a new wave of addiction,  
32           abuse, and injury.
- 33           g. Defendants' dereliction of duties and/or fraudulent misinformation  
34           campaign pushing dangerous drugs resulted in a diverted supply of  
35           narcotics to sell, and the ensuing demand of addicts to buy them.  
36           More prescription opioids sold by Defendants led to more addiction,  
37           with many addicts turning from prescription opioids to heroin. People  
38           addicted to opioids frequently require increasing levels of opioids,  
39           and many are turning to heroin as a foreseeable result.

- h. The diversion of opioids into the secondary, criminal market and the increased number of individuals who abuse or are addicted to opioids has increased and continues to increase the demands on health care services and law enforcement.
    - i. The significant and unreasonable interference with the public rights caused by Defendants' conduct has taxed and continues to tax the human, medical, public health, law enforcement, and financial resources of the Plaintiffs' Community.

407. The People seek all legal and equitable relief as allowed by law, other than such damages disavowed herein, including *inter alia* injunctive relief and expenses to prospectively abate the nuisance.

9        408. Pursuant to California Code of Civil Procedure section 731, The  
10 People request an order from the Court on behalf of The People providing for  
11 abatement of Defendants' ongoing violations of California Civil Code Sections  
12 3479 and 3480, and enjoining Defendants from future violations of California  
13 Civil Code Sections 3479 and 3480.

14        409. Each Defendant created or assisted in the creation of the epidemic of  
15 opioid use and injury and each Defendant is jointly and severally liable for abating  
16 it.

# COUNT II

## PUBLIC NUISANCE

**(Brought by The County Against all Defendants)**

20       410. Plaintiff, The County, incorporates by reference all other paragraphs  
21 of this Complaint as if fully set forth here, and further alleges as follows.

22        411. As set forth above, each Defendant is liable for public nuisance  
23 because its conduct at issue has caused an unreasonable and substantial  
24 interference with a right common to the general public. *See, e.g., Cty. of Santa*  
25 *Clara v. Atl. Richfield Co.*, 137 Cal. App. 4th 292, 305, 40 Cal. Rptr. 3d 313, 325  
26 (2006); Cal. Civ. Code §§ 3479; 3480.

27 ||| 412. Defendants have created a public nuisance under California law.

1       413. The County has standing to bring this claim for damages incurred to  
2 its property by the public nuisance due to the opioid epidemic which was created  
3 by Defendants and which is affecting and causing harm to The County. An action  
4 can be “brought by any person whose property is injuriously affected, or whose  
5 personal enjoyment is lessened by a nuisance, as defined in Section 3479 of the  
6 Civil Code, and by the judgment in that action the nuisance may be enjoined or  
7 abated as well as damages recovered therefor.” Cal. Civ. Proc. Code § 731.  
8 “Where a public entity can show it has a property interest injuriously affected by  
9 the nuisance, then, like any other such property holder, it should be able to pursue  
10 the full panoply of tort remedies available to private persons.” *Selma Pressure*  
11 *Treating Co. v. Osmose Wood Preserving Co.*, 221 Cal. App. 3d 1601, 1616, 271  
12 Cal. Rptr. 596, 604 (Ct. App. 1990).

13       414. The County has suffered harm to its property interests that is  
14 different from the type of harm suffered by the general public and has incurred  
15 substantial costs deriving from having to replace and retrofit its property that has  
16 been damaged and is being damaged by Defendants’ intentional, unlawful, and  
17 reckless manufacturing, marketing, distribution, promotion and sale of  
18 prescription opioids.

19       415. Defendants intentionally, unlawfully, and recklessly manufacture,  
20 market, distribute, promote and sell prescription opioids that Defendants know, or  
21 reasonably should know, will be diverted, causing widespread distribution of  
22 prescription opioids in and/or to Plaintiffs’ Community, resulting in The County  
23 having to repair and remake its infrastructure, property and systems that have been  
24 damaged by Defendants’ action, including, *inter alia*, its property and systems to  
25 treat addiction and abuse, to respond to and manage an elevated level of  
26 emergencies and crime, and to respond to and treat injuries and process deaths in  
27 Plaintiffs’ Community.

28

1       416. The County owns property which has been injuriously affected by the  
2 public nuisance caused by Defendants. These property interests, include, *inter*  
3 *alia*, additional naloxone doses – The County owns these doses which have been  
4 and are destroyed when The County has to administer them to persons who are  
5 overdosing as a result of Defendants' intentional, unlawful, and reckless  
6 manufacturing, marketing, distribution, promotion and sale of prescription  
7 opioids. The County's emergency response system and medical services  
8 equipment and other materials will similarly need to be improved and replaced  
9 because this property has been and is being damaged due to persons who are  
10 overdosing as a result of Defendants' intentional, unlawful, and reckless  
11 manufacturing, marketing, distribution, promotion and sale of prescription  
12 opioids. The County also has damage to its property related to evidence gathering  
13 and testing for the prosecution of drug related crimes.

14       417. In addition, The County has suffered damages to its infrastructure,  
15 which will need to be retrofitted and repaired as a result of Defendants'  
16 intentional, unlawful, and reckless manufacturing, marketing, distribution,  
17 promotion and sale of prescription opioids. This damage includes damage to its  
18 law enforcement, medical and rehabilitation infrastructures and systems which are  
19 now inadequate to handle the new undue burden on these systems caused by  
20 Defendants' conduct. This includes, *inter alia*, repairing and upgrading jail  
21 facilities to add additional jail space and beds for opioid addicts who commit  
22 crimes as well as retrofitting the facilities to treat inmates' addictions. This also  
23 includes repairing and upgrading court systems for prosecution and defense of  
24 drug-related crimes. This also includes repairing and upgrading hospital and  
25 treatment facilities for members of Plaintiffs' Community addicted to opioids as  
26 well as property that is part of and used by The County's Department of the  
27 Medical Examiner which must investigate deaths known or suspected to be due to  
28 drug intoxication.

1           418. The County owns, operates, manages, maintains, and otherwise has  
2 property interests in, all of which have been injured, damaged, or affected by  
3 Defendants, the following property:

- 4           a. County Jail system, including buildings, cells, beds, supplies,  
5           resources, materials, personnel, equipment, and other property.
- 6           b. County Probation system, including offices, personnel, supplies,  
7           resources, materials, equipment, and other property.
- 8           c. County District Attorney system, including offices, personnel,  
9           supplies, resources, materials, equipment, and other property.
- 10          d. County Health and Human Services system, including offices,  
11           personnel, supplies, resources, materials, equipment, and other  
12           property.
- 13          e. County Sheriff and Law Enforcement systems, including Narcan,  
14           naloxone, offices, personnel, supplies, resources, materials,  
15           equipment, and other property.
- 16          f. County Emergency Responder system, including equipment, Narcan,  
17           naloxone, materials, supplies, personnel, offices, and other property.
- 18          g. County Public Health system, including offices, personnel, resources,  
19           supplies, equipment, materials, and other property.
- 20          h. County Medical Examiner system, including personnel, offices,  
21           supplies, equipment, materials, resources, and other property.
- 22          i. County Public Defender System, including personnel, offices,  
23           supplies, equipment, materials, resources, and other property.

24           419. As set forth above in allegations specifically incorporated herein, by  
25 selling dangerously addictive opioid drugs diverted from a legitimate medical,  
26 scientific, or industrial purpose, Defendants have committed a course of conduct  
27 that injuriously affects The County and its property.

28

1           420. The public nuisance caused by Defendants' affirmative promotion of  
2 opioids has caused substantial annoyance, inconvenience, and injury to The  
3 County and The County's property.

4           421. The acts by Defendants which have injured The County and its  
5 property are unreasonable because there is little social utility to opioid diversion  
6 and abuse, and any potential value is outweighed by the gravity of the harm  
7 inflicted by Defendants' actions.

8           422. Defendants have unlawfully and/or intentionally caused and  
9 permitted dangerous drugs under their control to be diverted such as to injure the  
10 County's property.

11          423. Defendants' conduct in illegally distributing and selling prescription  
12 opioids, or causing such opioids to be distributed and sold, where Defendants  
13 know, or reasonably should know, such opioids will be diverted and possessed  
14 and/or used illegally in Plaintiffs' Community is of a continuing nature and has  
15 produced a significant injury to The County and its property.

16          424. Defendants' ongoing conduct produces an ongoing nuisance.

17          425. Defendants know, or reasonably should know, that their conduct will  
18 have an ongoing detrimental effect upon The County and The County's property.

19          426. Defendants' actions were, at the least, a substantial factor causing the  
20 harm to The County and its property.

21          427. The presence of diverted prescription opioids in Plaintiffs'  
22 Community, and the consequence of prescription opioids having been diverted in  
23 Plaintiffs' Community, proximately results in and/or substantially contributes to  
24 the creation of significant past and future costs to The County as it must repair and  
25 retrofit its property in order to enforce the law and treat the victims of opioid  
26 abuse and addiction.

27

28

1       428. Defendants' conduct is a direct and proximate cause of and/or a  
2 substantial contributing factor to opioid addiction and abuse in Plaintiffs'  
3 Community, costs that will be borne by Plaintiffs' Community and The County.

4       429. As a direct and proximate result of Defendants' creation of a public  
5 nuisance, The County has suffered and continues to suffer damages to its property  
6 requiring investigation, repair, remediation, and other costs to be determined at  
7 trial.

8       430. The damages available to The County include, *inter alia*, recoupment  
9 of governmental costs, flowing from the damages to The County's property which  
10 The County seeks to recover damages for. Defendants' conduct is ongoing and  
11 persistent, and The County seeks all damages flowing from Defendants' conduct.

12       431. As a direct result of Defendants' conduct, The County and Plaintiffs'  
13 Community have suffered actual injury and damages including, but not limited to,  
14 significant expenses for repairing and retrofitting property related to police,  
15 emergency, health, prosecution, corrections and other services. The County here  
16 seeks recovery for its own harm.

17       432. The County has sustained specific and special injuries because its  
18 damages include, *inter alia*, injury to the property and systems of its health  
19 services, law enforcement, and medical examiner, as well as property costs related  
20 to opioid addiction treatment and overdose prevention, as described in this  
21 Complaint.

22       433. The County seeks all legal and equitable relief as allowed by law,  
23 including *inter alia* compensatory damages, from the Defendants for the creation  
24 of a public nuisance, attorney fees and costs, and pre- and post-judgment interest.  
25  
26  
27  
28

**COUNT III**  
**RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT**  
**18 U.S.C. § 1961, et seq.**  
**(Against Defendants Purdue, Cephalon, Janssen, and Endo)**  
**(The “Opioid Marketing Enterprise”)**

434. Plaintiff, The County, incorporates by reference all other paragraphs of this Complaint as if fully set forth herein, and further alleges as follows.

435. Plaintiff, The County, brings this Count on behalf of itself against the following Defendants, as defined above: Purdue, Cephalon, Janssen, and Endo (referred to collectively for this Claim as the “RICO Marketing Defendants”).

436. At all relevant times, the RICO Marketing Defendants were and are “persons” under 18 U.S.C. § 1961(3) because they are entities capable of holding, and do hold, “a legal or beneficial interest in property.”

437. Section 1962(c) of RICO makes it unlawful “for any person employed by or associated with any enterprise engaged in, or the activities of which affect, interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise’s affairs through a pattern of racketeering activity.” 18 U.S.C. § 1962(c).

438. The term “enterprise” is defined as including “any individual, partnership, corporation, association, or other legal entity, and any union or group of individuals associated in fact although not a legal entity.” 18 U.S.C. § 1961(4). The definition of “enterprise” in Section 1961(4) includes legitimate and illegitimate enterprises within its scope. Specifically, the section “describes two separate categories of associations that come within the purview of an ‘enterprise’ -- the first encompassing organizations such as corporations, partnerships, and other ‘legal entities,’ and the second covering ‘any union or group of individuals associated in fact although not a legal entity.’” *United States v. Turkette*, 452 U.S. 576, 577 (1981).

1       439. Beginning in the early 1990s, the RICO Marketing Defendants  
2 aggressively sought to bolster their revenue, increase profit, and grow their share  
3 of the prescription painkiller market by unlawfully increasing the volume of  
4 opioids they sold. The RICO Marketing Defendants knew that they could not  
5 increase their profits without misrepresenting that opioids were non-addictive and  
6 safe for the long-term treatment of chronic pain.

7       440. The generally accepted standards of medical practice prior to the  
8 1990s dictated that opioids should only be used in short durations to treat acute  
9 pain, pain relating to recovery from surgery, or for cancer or palliative (end-of-  
10 life) care. Due to the evidence of addiction and lack of evidence indicating that  
11 opioids improved patients' ability to overcome pain and function, the use of  
12 opioids for chronic pain was discouraged or prohibited. As a result, doctors  
13 generally did not prescribe opioids for chronic pain.

14       441. Knowing that their products were highly addictive, ineffective and  
15 unsafe for the treatment of long-term chronic pain, non-acute and non-cancer pain,  
16 the RICO Marketing Defendants formed an association-in-fact enterprise and  
17 engaged in a scheme to unlawfully increase their profits and sales, and grow their  
18 share of the prescription painkiller market, through repeated and systematic  
19 misrepresentations about the safety and efficacy of opioids for treating long-term  
20 chronic pain.

21       442. The RICO Marketing Defendants formed an association-in-fact  
22 enterprise consisting of “advocacy groups and professional societies” (“Front  
23 Groups”) and paid “physicians affiliated with these groups” (KOLs”) in order to  
24 unlawfully increase the demand for opioids. Through their personal relationships,  
25 the RICO Marketing Defendants and members of the Opioid Marketing Enterprise  
26 had the opportunity to form and take actions in furtherance of the Opioid  
27 Marketing Enterprise’s common purpose. The RICO Marketing Defendants’  
28

1 substantial financial contribution to the Opioid Marketing Enterprise, and the  
 2 advancement of opioids-friendly messaging, fueled the U.S. opioids epidemic.<sup>203</sup>

3       443. The RICO Marketing Defendants, through the Opioid Marketing  
 4 Enterprise, made misleading statements and misrepresentations about opioids that  
 5 downplayed the risk of addiction and exaggerated the benefits of opioid use,  
 6 including: (1) downplaying the serious risk of addiction; (2) creating and  
 7 promoting the concept of “pseudoaddiction” when signs of actual addiction began  
 8 appearing and advocated that the signs of addiction should be treated with more  
 9 opioids; (3) exaggerating the effectiveness of screening tools to prevent addiction;  
 10 (4) claiming that opioid dependence and withdrawal are easily managed; (5)  
 11 denying the risks of higher opioid dosages; and (6) exaggerating the effectiveness  
 12 of “abuse-deterrant” opioid formulations to prevent abuse and addiction.

13       444. The RICO Marketing Defendants also falsely touted the benefits of  
 14 long-term opioid use, including the supposed ability of opioids to improve  
 15 function and quality of life, even though there was no scientifically reliable  
 16 evidence to support the RICO Marketing Defendants’ claims.

17       445. The RICO Marketing Defendants’ scheme, and the common purpose  
 18 of the Opioid Marketing Enterprise, has been wildly successful. Opioids are now  
 19 the most prescribed class of drugs. Globally, opioid sales generated \$11 billion in  
 20 revenue for drug companies in 2010 alone; sales in the United States have  
 21 exceeded \$8 billion in revenue annually since 2009.<sup>204</sup> In an open letter to the  
 22 nation’s physicians in August 2016, the then-U.S. Surgeon General expressly  
 23

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24       <sup>203</sup> *Fueling an Epidemic: Exposing the Financial Ties Between Opioid*  
 25 *Manufacturers and Third Party Advocacy Groups*, U.S. Senate Homeland Security  
 & Governmental Affairs Committee, Ranking Members’ Office, February 12,  
 2018 <https://www.hsdl.org/?abstract&did=808171> (“*Fueling an Epidemic*”), at 1.

26       <sup>204</sup> See Katherine Eban, *OxyContin: Purdue Pharma’s Painful Medicine*, Fortune,  
 27 Nov. 9, 2011, <http://fortune.com/2011/11/09/oxycontin-purdue-pharmas-painful-medicine/>; David Crow, *Drugmakers Hooked on \$10bn Opioid Habit*, Fin. Times, Aug. 10, 2016, <https://www.ft.com/content/f6e989a8-5dac-11e6-bb77-a121aa8abd95>.

1 connected this “urgent health crisis” to “heavy marketing of opioids to doctors . . .  
 2 [m]any of [whom] were even taught – incorrectly – that opioids are not addictive  
 3 when prescribed for legitimate pain.”<sup>205</sup>

4       446. The scheme devised and implemented by the RICO Marketing  
 5 Defendants amounted to a common course of conduct designed to ensure that the  
 6 RICO Marketing Defendants unlawfully increased their sales and profits through  
 7 misrepresentations about the addictive nature and effective use of the RICO  
 8 Marketing Defendants’ drugs. As Senator McCaskill aptly recognized:

9           The opioid epidemic is the direct result of a calculated marketing and  
 10 sales strategy developed in the 90’s, which delivered three simple  
 11 messages to physicians. First, that chronic pain was severely  
 12 undertreated in the United States. Second, that opioids were the best  
 13 tool to address that pain. And third, that opioids could treat pain  
 14 without risk of serious addiction. As it turns out, these messages were  
 15 exaggerations at best and outright lies at worst.<sup>206</sup>

#### **A. THE OPIOID MARKETING ENTERPRISE**

16       447. The Opioid Marketing Enterprise consists of the RICO Marketing  
 17 Defendants, the Front Groups, and the KOLs – each of whom is identified below:

- 18       • The RICO Defendants
  - 19           ○ Purdue
  - 20           ○ Cephalon
  - 21           ○ Janssen
  - 22           ○ Endo
- 23       • The Front Groups
  - 24           ○ American Pain Foundation (“APF”)
  - 25           ○ American Academy of Pain Medicine (“AAPM”)
  - 26           ○ American Pain Society (“APS”)

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27       <sup>205</sup> Letter from Vivek H. Murthy, U.S. Surgeon General (Aug. 2016),  
 28       <http://turnthetiderx.org/>; *Fueling An Epidemic*, *supra* n.3, at 1.

29       <sup>206</sup> See, *LIVESTREAM: Insys Opioid Sales and Marketing Practices Roundtable*,  
 30       September 12, 2017, at 31:03-31:37,  
 31       [https://www.youtube.com/watch?v=k9mrQa8\\_vAo](https://www.youtube.com/watch?v=k9mrQa8_vAo) (accessed on March 1, 2018).

- 1                   ○ Federation of State Medical Boards (“FSMB”)
- 2                   ○ U.S. Pain Foundation (“USPF”)
- 3                   ○ American Geriatrics Society (“AGS”)
- 4     • The KOLs
  - 5                   ○ Dr. Russell Portenoy (“Dr. Portenoy”)
  - 6                   ○ Dr. Lynn Webster (“Dr. Webster”)
  - 7                   ○ Dr. Perry Fine (“Dr. Fine”)
  - 8                   ○ Dr. Scott M. Fishman (“Dr. Fishman”))

9  
10       448. The Opioid Marketing Enterprise is an ongoing and continuing  
11 business organization that created and maintained systematic links, interpersonal  
12 relationships and engaged in a pattern of predicate acts (i.e. racketeering activity)  
13 in order to further the common purpose of the enterprise: unlawfully increasing  
14 profits and revenues from the continued prescription and use of opioids for long-  
15 term chronic pain. Each of the individuals and entities who formed the Opioid  
16 Marketing Enterprise is an entity or person within the meaning of 18 U.S.C. §  
17 1961(3) and acted to enable the common purpose and fraudulent scheme of the  
18 Opioid Marketing Enterprise.

19       449. In order to accomplish the common purpose, members of the Opioid  
20 Marketing Enterprise repeatedly and systematically misrepresented –  
21 affirmatively, and through half-truths and omissions – that opioids are non-  
22 addictive and safe for the effective treatment of long-term, chronic, non-acute and  
23 non-cancer pain, and for other off-label uses not approved by the FDA. The  
24 Opioid Marketing Enterprise misrepresented and concealed the serious risks and  
25 lack of corresponding benefits of using opioids for long-term chronic pain. By  
26 making these misrepresentations, the Opioid Marketing Enterprise ensured that a  
27 large number of opioid prescriptions would be written and filled for chronic pain.  
28

1       450. At all relevant times, the Opioid Marketing Enterprise: (a) had an  
2 existence separate and distinct from each RICO Marketing Defendant and its  
3 members; (b) was separate and distinct from the pattern of racketeering in which  
4 the RICO Defendants engaged; (c) was an ongoing and continuing organization  
5 consisting of individuals, persons, and legal entities, including each of the RICO  
6 Marketing Defendants; (d) was characterized by interpersonal relationships  
7 between and among each member of the Opioid Marketing Enterprise, including  
8 between the RICO Marketing Defendants and each of the Front Groups and  
9 KOLs; (e) had sufficient longevity for the enterprise to pursue its purpose; and (f)  
10 functioned as a continuing unit.

11       451. The persons and entities engaged in the Opioid Marketing Enterprise  
12 are systematically linked through contractual relationships, financial ties, personal  
13 relationships, and continuing coordination of activities, as spearheaded by the  
14 RICO Marketing Defendants.

15       452. Each of the RICO Marketing Defendants, and each member of the  
16 Opioid Marketing Enterprise had systematic links to and personal relationships  
17 with each other through joint participation in lobbying groups, trade industry  
18 organizations, contractual relationships and continuing coordination of activities.  
19 Each of the RICO Marketing Defendants coordinated their marketing efforts  
20 through the same KOLs and Front Groups, based on their agreement and  
21 understanding that the Front Groups and KOLs were industry friendly and would  
22 work together with the RICO Marketing Defendants to advance the common  
23 purpose of the Opioid Marketing Enterprise.

24                   **1. The RICO Defendants**

25       453. In addition to their systematic links to and personal relationships with  
26 the Front Groups and KOLS, described below, the RICO Marketing Defendants  
27 had systematic links to and personal relationships with each other through their  
28 participation in lobbying groups, trade industry organizations, contractual

1 relationships and continuing coordination of activities, including but not limited  
 2 to, the Pain Care Forum (“PCF”) and the Healthcare Distribution Alliance  
 3 (“HDA”).

4       454. The PCF has been described as a coalition of drug makers, trade  
 5 groups and dozens of non-profit organizations supported by industry funding.  
 6 Plaintiffs are informed and believe that the PCF was created with the stated goal  
 7 of offering a “setting where multiple organizations can share information” and  
 8 “promote and support taking collaborative action regarding federal pain policy  
 9 issues.” Plaintiffs are informed and believe that past APF President Will Rowe  
 10 described the PCF as “a deliberate effort to positively merge the capacities of  
 11 industry, professional associations, and patient organizations.”

12       455. The PCF recently became a national news story when it was  
 13 discovered that lobbyists for members of the PCF, including the RICO Marketing  
 14 Defendants, quietly shaped federal and state policies regarding the use of  
 15 prescription opioids for more than a decade.

16       456. The Center for Public Integrity and The Associated Press obtained  
 17 “internal documents shed[ding] new light on how drug makers and their allies  
 18 shaped the national response to the ongoing wave of prescription opioid abuse.”<sup>207</sup>  
 19 Specifically, PCF members spent over \$740 million lobbying in the nation’s  
 20 capital and in all 50 statehouses on an array of issues, including opioid-related  
 21 measures.<sup>208</sup>

22       457. Not surprisingly, each of the RICO Marketing Defendants who stood  
 23 to profit from lobbying in favor of prescription opioid use is a member of and/or  
 24  
 25

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26       207 Matthew Perrone, Pro-Painkiller echo chamber shaped policy amid drug  
 27 epidemic, The Center for Public Integrity (September 19, 2017, 12:01 a.m.),  
 28 <https://www.publicintegrity.org/2016/09/19/20201/pro-painkiller-echo-chamber-shaped-policy-amid-drug-epidemic> (emphasis added).

208 *Id.*

1 participant in the PCF.<sup>209</sup> In 2012, membership and participating organizations in  
 2 the PCF included the HDA (of which all the RICO Defendants are members),  
 3 Endo, Purdue, Johnson & Johnson (the parent company for Janssen  
 4 Pharmaceuticals), and Teva (the parent company of Cephalon).<sup>210</sup> Each of the  
 5 RICO Marketing Defendants worked together through the PCF to advance the  
 6 interests of the Opioid Marketing Enterprise. But, the RICO Marketing  
 7 Defendants were not alone, many of the RICO Marketing Defendants' Front  
 8 Groups were also members of the PCF, including the American Academy of Pain  
 9 Management, the American Pain Foundation, and the American Pain Society.  
 10 Upon information and belief, the RICO Marketing Defendants' KOLs were also  
 11 members of and participated in the PCF.

12       458. Through the Pain Care Forum, the RICO Marketing Defendants met  
 13 regularly and in person to form and take action to further the common purpose of  
 14 the Opioid Marketing Enterprise and shape the national response to the ongoing  
 15 prescription opioid epidemic.

16       459. Through the HDA – or Healthcare Distribution Alliance – the RICO  
 17 Marketing Defendants “strengthen[ed] . . . alliances”<sup>211</sup> and took actions to further  
 18 the common purpose of the Opioid Marketing Enterprise.

19       460. Beyond strengthening alliances, the benefits of HDA membership  
 20 included the ability to, among other things, “network one on one with  
 21 manufacturer executives at HDA’s members-only Business and Leadership  
 22 Conference,” “participate on HDA committees, task forces and working groups

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24       <sup>209</sup> PAIN CARE FORUM 2012 Meetings Schedule, (last updated December 2011),  
 25 <https://assets.documentcloud.org/documents/3108982/PAIN-CARE-FORUM-Meetings-Schedule-amp.pdf> (last visited March 8, 2018).

26       <sup>210</sup> *Id.* Upon information and belief, Mallinckrodt became an active member of the  
 27 PCF sometime after 2012.

28       <sup>211</sup> Manufacturer Membership Benefits, Healthcare Distribution Alliance, (accessed on September 14, 2017),  
<https://www.healthcaredistribution.org/~media/pdfs/membership/manufacturer-membership-benefits.ashx?la=en> (emphasis added).

1 with peers and trading partners,” and “make connections.”<sup>212</sup> Clearly,  
 2 membership in the HDA was an opportunity to create interpersonal and ongoing  
 3 organizational relationships and “alliances” between the RICO Marketing  
 4 Defendants.

5       461. The closed meetings of the HDA’s councils, committees, task forces  
 6 and working groups provided the RICO Marketing Defendants with the  
 7 opportunity to work closely together, confidentially, to develop and further the  
 8 common purpose and interests of the Opioid Marketing Enterprise.

9       462. The HDA also offered multiple conferences, including annual  
 10 business and leadership conferences through which the RICO Marketing  
 11 Defendants had an opportunity to “bring together high-level executives, thought  
 12 leaders and influential managers . . . to hold strategic business discussions on the  
 13 most pressing industry issues.”<sup>213</sup> The HDA and its conferences were significant  
 14 opportunities for the RICO Marketing Defendants to interact at the executive level  
 15 and form and take actions in furtherance of the common purpose of the Opioid  
 16 Marketing Enterprise. It is clear that the RICO Marketing Defendants embraced  
 17 this opportunity by attending and sponsoring these events.<sup>214</sup>

18       463. The systematic contacts and personal relationships developed by the  
 19 RICO Marketing Defendants through the PCF and the HDA furthered the  
 20 common purpose of the Opioid Marketing Enterprise because it allowed the RICO  
 21 Marketing Defendants to coordinate the conduct of the Opioid Marketing

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22  
 23  
 24       <sup>212</sup> *Id.*

25       <sup>213</sup> Business and Leadership Conference – Information for Manufacturers,  
 26 Healthcare Distribution  
 27 Alliance<https://www.healthcaredistribution.org/events/2015-business-and-leadership-conference/blc-for-manufacturers> (last accessed on September 14, 2017).

28       <sup>214</sup> 2015 Distribution Management Conference and Expo, Healthcare Distribution  
 29 Alliance, <https://www.healthcaredistribution.org/events/2015-distribution-management-conference> (last accessed on September 14, 2017).

1 Enterprise by, including but not limited to, coordinating their interaction and  
2 development of relationships with the Front Groups and KOLs.

3 **2. The Front Groups**

4 464. Each of the RICO Marketing Defendants had systematic links to and  
5 personal relationships with Front Groups that operated as part of the Opioid  
6 Marketing Enterprise to further the common purpose of unlawfully increasing  
7 sales by misrepresenting the non-addictive and effective use of opioids for the  
8 treatment of long-term chronic pain. As recently reported by the U.S. Senate in  
9 “*Fueling an Epidemic*”:

10 The fact that these same manufacturers provided millions of dollars to  
11 the groups described below suggests, at the very least, a direct link  
12 between corporate donations and the advancement of opioids-friendly  
13 messaging. By aligning medical culture with industry goals in this  
14 way, many of the groups described in this report may have played a  
15 significant role in creating the necessary conditions for the U.S.  
16 opioids epidemic.<sup>215</sup>

17 465. “Patient advocacy organizations and professional societies like the  
18 Front Groups ‘play a significant role in shaping health policy debates, setting  
19 national guidelines for patient treatment, raising disease awareness, and educating  
20 the public.’<sup>216</sup> ‘Even small organizations—with ‘their large numbers and  
21 credibility with policymakers and the public’—have ‘extensive influence in  
22 specific disease areas.’ Larger organizations with extensive funding and outreach  
23 capabilities ‘likely have a substantial effect on policies relevant to their industry  
24 sponsors.’<sup>217</sup> Indeed, as reflected below, the U.S. Senate’s report found that the  
25 RICO Marketing Defendants made nearly \$9 million worth of contributions to  
26 various Front Groups, including members of the Opioid Marketing Enterprise.<sup>218</sup>

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26 <sup>215</sup> *Fueling an Epidemic*, at p. 1.

27 <sup>216</sup> *Id.* at p. 2

28 <sup>217</sup> *Id.*

<sup>218</sup> *Id.* at p. 3.

1 FIGURE 1: Manufacturer Payments to Selected Groups, 2012-2017  
2

	Purdue <sup>22</sup>	Janssen <sup>23</sup>	Depomed	Insys	Mylan	Total
<b>Academy of Integrative Pain Management</b>	\$1,091,024.86	\$128,000.00	\$43,491.95	\$3,050.00 <sup>24</sup>	\$0.00	<b>\$1,265,566.81</b>
<b>American Academy of Pain Medicine</b>	\$725,584.95	\$83,975.00	\$332,100.00	\$57,750.00	\$0.00	<b>\$1,199,409.95</b>
<b>AAPM Foundation</b>	\$0.00	\$0.00	\$304,605.00	\$0.00	\$0.00	<b>\$304,605.00</b>
<b>ACS Cancer Action Network</b>	\$168,500.00 <sup>25</sup>	\$0.00	\$0.00	\$0.00	\$0.00	<b>\$168,500.00</b>
<b>American Chronic Pain Association</b>	\$312,470.00	\$50,000.00	\$54,670.00	\$0.00	\$0.00	<b>\$417,140.00</b>
<b>American Geriatrics Society</b>	\$11,785.00 <sup>26</sup>	\$0.00	\$0.00	\$0.00	\$0.00	<b>\$11,785.00</b>
<b>American Pain Foundation</b>	\$25,000.00	\$0.00	\$0.00	\$0.00	\$0.00	<b>\$25,000.00</b>
<b>American Pain Society</b>	\$542,259.52	\$88,500.00	\$288,750.00	\$22,965.00	\$20,250.00	<b>\$962,724.52</b>
<b>American Society of Pain Educators</b>	\$30,000.00	\$0.00	\$0.00	\$0.00	\$0.00	<b>\$30,000.00</b>
<b>American Society of Pain Management Nursing</b>	\$242,535.00	\$55,177.85 <sup>27</sup>	\$25,500.00 <sup>28</sup>	\$0.00	\$0.00	<b>\$323,212.85</b>
<b>The Center for Practical Bioethics</b>	\$145,095.00	\$18,000.00	\$0.00	\$0.00	\$0.00	<b>\$163,095.00</b>
<b>The National Pain Foundation<sup>29</sup></b>	\$0.00	\$0.00	\$0.00	\$562,500.00	\$0.00	<b>\$562,500.00</b>
<b>U.S. Pain Foundation</b>	\$359,300.00	\$41,500.00	\$22,000.00	\$2,500,000.00 <sup>30</sup>	\$0.00	<b>\$2,922,800.00</b>
<b>Washington Legal Foundation</b>	\$500,000.00	\$0.00	\$0.00	\$0.00	\$0.00	<b>\$500,000.00</b>
	<b>\$4,153,554.33</b>	<b>\$465,152.85</b>	<b>\$1,071,116.95</b>	<b>\$3,146,265.00</b>	<b>\$20,250.00</b>	<b>\$8,856,339.13</b>

23        466. The Front Groups included in the Opioid Marketing Enterprise “have  
 24 promoted messages and policies favorable to opioid use while receiving millions  
 25 of dollars in payments from opioid manufacturers. Through criticism of  
 26 government prescribing guidelines, minimization of opioid addiction risk, and  
 27 other efforts, ostensibly neutral advocacy organizations have often supported  
 28

1 industry interests at the expense of their own constituencies.<sup>219</sup> And, as reflected  
 2 below, many of the RICO Marketing Defendants' Front Groups received the  
 3 largest contributions:

4 FIGURE 5: Group Rankings by Manufacturer Payments, 2012-2017

<b>U.S. Pain Foundation</b>	\$2,922,800.00
<b>Academy of Integrative Pain Management</b>	\$1,265,566.81
<b>American Academy of Pain Medicine</b>	\$1,199,409.95
<b>American Pain Society</b>	\$962,724.52
<b>The National Pain Foundation</b>	\$562,500.00
<b>Washington Legal Foundation</b>	\$500,000.00
<b>American Chronic Pain Association</b>	\$417,140.00
<b>American Society of Pain Management Nursing</b>	\$323,212.85
<b>AAPM Foundation</b>	\$304,605.00
<b>ACS Cancer Action Network</b>	\$168,500.00
<b>The Center for Practical Bioethics</b>	\$163,095.00
<b>American Society of Pain Educators</b>	\$30,000.00
<b>American Pain Foundation</b>	\$25,000.00
<b>American Geriatrics Society</b>	\$11,785.00

15        467. But, the RICO Marketing Defendants connection with and control  
 16 over the Front Groups did not end with financial contributions. Rather, the RICO  
 17 Marketing Defendants made substantial contributions to physicians affiliated with  
 18 the Front Groups totaling more than \$1.6 million.<sup>220</sup> Moreover, the RICO  
 19 Marketing Defendants "made substantial payments to individual group executives,  
 20 staff members, board members, and advisory board members" affiliated with the  
 21 Front Groups subject to the Senate Committee's study.<sup>221</sup>

22  
 23  
 24  
 25  
 26

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27 <sup>219</sup> *Id.* at p. 3.

28 <sup>220</sup> *Id.* at p. 3.

<sup>221</sup> *Id.* at p. 10.

1       468. As described in more detail below<sup>222</sup>, the RICO Marketing  
 2 Defendants “amplified or issued messages that reinforce industry efforts to  
 3 promote opioid prescription and use, including guidelines and policies minimizing  
 4 the risk of addiction and promoting opioids for chronic pain.”<sup>223</sup> They also  
 5 “lobbied to change laws directed at curbing opioid use, strongly criticized  
 6 landmark CDC guidelines on opioid prescribing, and challenged legal efforts to  
 7 hold physicians and industry executives responsible for overprescription and  
 8 misbranding.”<sup>224</sup>

9  
 10 FIGURE 7: Purdue, Janssen, Insys, Depomed, and Mylan Payments to Groups and Group-  
     Affiliated Individuals, 2012-Present<sup>41</sup>

	Payments to Group	Payments to Group-Affiliated Individuals	Total
<b>U.S. Pain Foundation</b>	\$2,922,800.00	\$126.20	\$2,922,926.20
<b>The National Pain Foundation</b>	\$562,500.00	\$839,848.84	\$1,402,348.84
<b>Academy of Integrative Pain Management</b>	\$1,265,566.81	\$30,223.42	\$1,295,790.23
<b>American Academy of Pain Medicine</b>	\$1,199,409.95	\$16,462.42	\$1,215,872.37
<b>American Pain Society</b>	\$962,724.52	\$95,474.56	\$1,058,199.08
<b>AAPM Foundation</b>	\$304,605.00	\$314,175.58	\$618,780.58
<b>Washington Legal Foundation</b>	\$500,000.00	N/A	\$500,000.00
<b>American Chronic Pain Association</b>	\$417,140.00	\$31,265.87	\$448,405.87
<b>American Society of Pain Management Nursing</b>	\$323,212.85	N/A	\$323,212.85
<b>American Society of Pain Educators</b>	\$30,000.00	\$280,765.92	\$310,765.92
<b>The Center for Practical Bioethics</b>	\$163,095.00	\$7,116.86	\$170,211.86
<b>ACS Cancer Action Network</b>	\$168,500.00	N/A	\$168,500.00
<b>American Pain Foundation</b>	\$25,000.00	N/A	\$25,000.00
<b>American Geriatrics Society</b>	\$11,785.00	\$194.13	\$11,979.13
<b>Total</b>	\$8,856,339.13	\$1,615,653.80	\$10,471,992.93

25  
 26       <sup>222</sup> The activities that the Front Groups engaged in, and the misrepresentations that  
     they made, in furtherance of the common purpose of the Opioid Marketing  
     Enterprise are alleged more fully below, under the heading “Conduct of the Opioid  
     Marketing Enterprise.”

27  
 28       <sup>223</sup> *Id.* at 12-15.

224 *Id.* at 12.

1       469. The systematic contacts and interpersonal relationships of the RICO  
2 Marketing Defendants, and the Front Groups are further described below:

3       470. The American Pain Foundation (“APF”) – The American Pain  
4 Foundation was the most prominent member of the RICO Defendants’ Front  
5 Groups and was funded almost exclusively by the RICO Marketing Defendants.  
6 Plaintiffs are informed and believe that APF received more than \$10 million in  
7 funding from the RICO Marketing Defendants between 2007 and the close of its  
8 business in May 2012. The APF had multiple contacts and personal relationships  
9 with the RICO Marketing Defendants through its many publishing and  
10 educational programs, funded and supported by the RICO Marketing Defendants.  
11 Plaintiffs are further informed and believe that between 2009 and 2010, APF  
12 received more than eighty percent (80%) of its operating budget from  
13 pharmaceutical industry sources. Including industry grants for specific projects,  
14 APF received about \$2.3 million from industry sources out of total income of  
15 about \$2.85 million in 2009; its budget for 2010 projected receipts of roughly \$2.9  
16 million from drug companies, out of total income of about \$3.5 million. By 2011,  
17 upon information and belief, APF was entirely dependent on incoming grants  
18 from Defendants Purdue, Cephalon, Endo, and others.

19       471. On information and belief, APF was often called upon to provide  
20 “patient representatives” for the RICO Marketing Defendants’ promotional  
21 activities, including for Purdue’s “Partners Against Pain” and Janssen’s “Let’s  
22 Talk Pain.” APF functioned largely as an advocate for the interests of the RICO  
23 Marketing Defendants, not patients. Indeed, upon information and belief, as early  
24 as 2001, Purdue told APF that the basis of a grant was Purdue’s desire to  
25 “strategically align its investments in nonprofit organizations that share [its]  
26 business interests.”

27       472. APF is also credited with creating the PCF in 2004. Plaintiffs are  
28 informed and believe that the PCF was created with the stated goal of offering a

1 “setting where multiple organizations can share information” and “promote and  
 2 support taking collaborative action regarding federal pain policy issues.”  
 3 Plaintiffs are informed and believe that past APF President Will Rowe described  
 4 the PCF as “a deliberate effort to positively merge the capacities of industry,  
 5 professional associations, and patient organizations.”

6       473. Upon information and belief, representatives of the RICO Marketing  
 7 Defendants, often at informal meetings at conferences, suggested activities and  
 8 publications for APF to pursue. APF then submitted grant proposals seeking to  
 9 fund these activities and publications, knowing that drug companies would  
 10 support projects conceived as a result of these communications.

11       474. Furthermore, APF’s Board of Directors was largely comprised of  
 12 doctors who were on Defendants’ payrolls, either as consultants or speakers at  
 13 medical events.<sup>225</sup> As described below, many of the KOLs involved in the Opioid  
 14 Marketing Enterprise also served in leadership positions within the APF.

15       475. In December 2011, a ProPublica investigation found that in 2010,  
 16 nearly 90% of APF’s funding came from the drug and medical device community,  
 17 including RICO Marketing Defendants.<sup>226</sup> More specifically, APF received  
 18 approximately \$2.3 million from industry sources out of total income of \$2.85  
 19 million in 2009. It’s budget for 2010 projected receipt of approximately \$2.9  
 20 million from drug companies, out of total income of approximately \$3.5 million.  
 21 In May 2012, the U.S. Senate Finance Committee began looking into APF to  
 22 determine the links, financial and otherwise, between the organization and the  
 23 manufacturers of opioid painkillers. Within days of being targeted by the Senate  
 24

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25       <sup>225</sup> Charles Ornstein and Tracy Weber, *The Champion of Painkillers*, ProPublica  
 26 (Dec. 23, 2011), <https://www.propublica.org/article/the-champion-of-painkillers>.

27       <sup>226</sup> Charles Ornstein & Tracy Weber, *Patient advocacy group funded by success of*  
 28 *painkiller drugs, probe finds*, Wash. Post (Dec. 23, 2011),  
[https://www.washingtonpost.com/national/healthscience/patient-advocacy-group-funded-by-success-of-painkiller-drugs-probefinds/2011/12/20/gIQAvgczDP\\_story.html?utm\\_term=.22049984c606.](https://www.washingtonpost.com/national/healthscience/patient-advocacy-group-funded-by-success-of-painkiller-drugs-probefinds/2011/12/20/gIQAvgczDP_story.html?utm_term=.22049984c606.)

1 investigation, APF's Board voted to dissolve the organization "due to irreparable  
 2 economic circumstances." APF "cease[d] to exist, effective immediately."<sup>227</sup>

3       476. The American Academy of Pain Medicine ("AAPM") – The AAPM  
 4 was another Front Group that had systematic ties and personal relationships with  
 5 the RICO Defendants. AAPM received over \$2.2 million in funding since 2009  
 6 from opioid manufacturers. AAPM maintained a corporate relations council,  
 7 whose members paid \$25,000 per year (on top of other funding) to participate.  
 8 The benefits included allowing members to present educational programs at off-  
 9 site dinner symposia in connection with AAPM's marquee event – its annual  
 10 meeting held in Palm Springs, California, or other resort locations. AAPM  
 11 describes the annual event as an "exclusive venue" for offering education  
 12 programs to doctors. Membership in the corporate relations council also allowed  
 13 drug company executives and marketing staff to meet with AAPM executive  
 14 committee members in small settings. The RICO Marketing Defendants were all  
 15 members of the council and presented deceptive programs to doctors who  
 16 attended this annual event.<sup>228</sup>

17       477. The RICO Marketing Defendants internally viewed AAPM as  
 18 "industry friendly," with RICO Defendants' advisors and speakers among its  
 19 active members. The RICO Marketing Defendants attended AAPM conferences,  
 20 funded its CMEs and satellite symposia, and distributed its publications. AAPM  
 21 conferences heavily emphasized sessions on opioids. AAPM presidents have  
 22 included top industry-supported KOLs like Perry Fine and Lynn Webster.

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23  
 24  
 25       227 Charles Ornstein & Tracy Weber, *Senate Panel Investigates Drug Companies' Ties to Pain Groups*, Wash. Post, May 8, 2012,  
 26 [https://www.washingtonpost.com/national/health-science/senate-panel-investigates-drug-companies-ties-to-pain-groups/2012/05/08/gIQA2X4qBU\\_story.html](https://www.washingtonpost.com/national/health-science/senate-panel-investigates-drug-companies-ties-to-pain-groups/2012/05/08/gIQA2X4qBU_story.html).  
 27

28       228 The American Academy of Pain Medicine, Pain Medicine DC The Governing Voices of Pain: Medicine, Science, and Government, March 24-27, 2011,  
<http://www.painmed.org/files/2011-annual-meeting-program-book.pdf>.

1       478. Upon information and belief, representatives of the RICO Marketing  
 2 Defendants, often at informal meetings at conferences, suggested activities and  
 3 publications for AAPM to pursue. AAPM then submitted grant proposals seeking  
 4 to fund these activities and publications, knowing that drug companies would  
 5 support projects conceived as a result of these communications.

6       479. Plaintiffs are informed and believe that members of AAPM's Board  
 7 of Directors were doctors who were on the RICO Marketing Defendants' payrolls,  
 8 either as consultants or speakers at medical events. As described below, many of  
 9 the KOLs involved in the Opioid Marketing Enterprise also served in leadership  
 10 positions within the AAPM.

11       480. The American Pain Society ("APS") – The APS was another Front  
 12 Group with systematic connections and interpersonal relationships with the RICO  
 13 Marketing Defendants. APS was one of the Front Groups investigated by  
 14 Senators Grassley and Baucus, as evidenced by their May 8, 2012 letter arising  
 15 out of their investigation of "extensive ties between companies that manufacture  
 16 and market opioids and non-profit organizations" that "helped created a body of  
 17 dubious information favoring opioids."<sup>229</sup>

18       481. Upon information and belief, representatives of the RICO Marketing  
 19 Defendants, often at informal meetings at conferences, suggested activities and  
 20 publications for APS to pursue. APS then submitted grant proposals seeking to  
 21 fund these activities and publications, knowing that drug companies would  
 22 support projects conceived as a result of these communications.

23       482. Plaintiffs are informed and believe that members of APS's Board of  
 24 Directors were doctors who were on the RICO Marketing Defendants' payrolls,

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26       229 Letter from U.S. Senators Charles E. Grassley and Max Baucus to Catherine  
 27 Underwood, Executive Director (May 8, 2012), American Pain Society,  
<https://www.finance.senate.gov/imo/media/doc/05092012%20Baucus%20Grassley%20Opioid%20Investigation%20Letter%20to%20American%20Pain%20Society.pdf>.

1 either as consultants or speakers at medical events. As described below, many of  
 2 the KOLs involved in the Opioid Marketing Enterprise also served in leadership  
 3 positions within the APS.

4       483. The Federation of State Medical Boards (“FSMB”) – FSMB was  
 5 another Front Group with systematic connections and interpersonal relationships  
 6 with the RICO Marketing Defendants. In addition to the contributions reported in  
 7 *Fueling an Epidemic*, a June 8, 2012 letter submitted by FSMB to the Senate  
 8 Finance Committee disclosed substantial payments from the RICO Marketing  
 9 Defendants beginning in 1997 and continuing through 2012.<sup>230</sup> Not surprisingly,  
 10 the FSMB was another one of the Front Groups investigated by Senators Grassley  
 11 and Baucus, as evidenced by their May 8, 2012 letter arising out of their  
 12 investigation of “extensive ties between companies that manufacture and market  
 13 opioids and non-profit organizations” that “helped created a body of dubious  
 14 information favoring opioids.”<sup>231</sup>

15       484. The U.S. Pain Foundation (“USPF”) – The USPF was another Front  
 16 Group with systematic connections and interpersonal relationships with the RICO  
 17 Marketing Defendants. The USPF was one of the largest recipients of  
 18 contributions from the RICO Marketing Defendants, collection nearly \$3 million  
 19 in payments between 2012 and 2015 alone.<sup>232</sup> The USPF was also a critical  
 20 component of the Opioid Marketing Enterprise’s lobbying efforts to reduce the  
 21 limits on over-prescription. The U.S. Pain Foundation advertises its ties to the  
 22 RICO Marketing Defendants, listing opioid manufacturers like Pfizer, Teva,  
 23

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24       230 June 8, 2012 Letter from Federation of State Medical Boards to U.S. Senators  
 25 Max Baucus and Charles Grassley.

26       231 Letter from U.S. Senators Charles E. Grassley and Max Baucus to Catherine  
 27 Underwood, Executive Director (May 8, 2012), American Pain Society,  
<https://www.finance.senate.gov/imo/media/doc/05092012%20Baucus%20Grassley%20Opioid%20Investigation%20Letter%20to%20American%20Pain%20Society.pdf>.

28       232 *Fueling an Epidemic*, at p. 4.

1 Depomed, Endo, Purdue, McNeil (i.e. Janssen), and Mallinckrodt as “Platinum,”  
 2 “Gold,” and “Basic” corporate members.<sup>233</sup> Industry Front Groups like the  
 3 American Academy of Pain Management, the American Academy of Pain  
 4 Medicine, the American Pain Society, and PhRMA are also members of varying  
 5 levels in the USPF.

6       485. American Geriatrics Society (“AGS”) – The AGS was another Front  
 7 Group with systematic connections and interpersonal relationships with the RICO  
 8 Defendants. The AGS was a large recipient of contributions from the RICO  
 9 Marketing Defendants, including Endo, Purdue and Janssen. AGS contracted  
 10 with the RICO Marketing Defendants to disseminate guidelines regarding the use  
 11 of opioids for chronic pain in 2002 (*The Management of Persistent Pain in Older*  
 12 *Persons*, hereinafter “2002 AGS Guidelines”) and 2009 (*Pharmacological*  
 13 *Management of Persistent Pain in Older Persons*,<sup>234</sup> hereinafter “2009 AGS  
 14 Guidelines”). According to news reports, AGS has received at least \$344,000 in  
 15 funding from opioid manufacturers since 2009.<sup>235</sup> AGS’s complicity in the  
 16 common purpose of the Opioid Marketing Enterprise is evidenced by the fact that  
 17 AGS internal discussions in August 2009 reveal that it did not want to receive-up  
 18 front funding from drug companies, which would suggest drug company  
 19 influence, but would instead accept commercial support to disseminate pro-opioid  
 20 publications.

21       486. Upon information and belief, representatives of the RICO Marketing  
 22 Defendants, often at informal meetings at conferences, suggested activities,  
 23

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24       <sup>233</sup> *Id.* at 12; Transparency, U.S. Pain Foundation,  
 25 <https://uspainfoundation.org/transparency/> (last accessed on March 9, 2018).

26       <sup>234</sup> *Pharmacological Management of Persistent Pain in Older Persons*, 57 J. Am.  
 27 Geriatrics Soc’y 1331, 1339, 1342 (2009), available at  
<https://www.nhqualitycampaign.org/files/AmericanGeriatricSociety-PainGuidelines2009.pdf> (last accessed on March 9, 2018).

28       <sup>235</sup> John Fauber & Ellen Gabler, *Narcotic Painkiller Use Booming Among Elderly*,  
 Milwaukee J. Sentinel, May 30, 2012.

1 lobbying efforts and publications for AGS to pursue. AGS then submitted grant  
2 proposals seeking to fund these activities and publications, knowing that drug  
3 companies would support projects conceived as a result of these communications.

4 487. Plaintiffs are informed and believe that members of AGS Board of  
5 Directors were doctors who were on the RICO Marketing Defendants' payrolls,  
6 either as consultants or speakers at medical events. As described below, many of  
7 the KOLs involved in the Opioid Marketing Enterprise also served in leadership  
8 positions within the AGS.

9 488. There was regular communication between each of the RICO  
10 Marketing Defendants, Front Groups and KOLs, in which information was shared,  
11 misrepresentations were coordinated, and payments were exchanged. Typically,  
12 the coordination, communication and payment occurred, and continues to occur,  
13 through the use of the wires and mail in which the RICO Markets Defendants,  
14 Front Groups, and KOLs share information necessary to overcome objections and  
15 resistance to the use of opioids for chronic pain. The RICO Marketing  
16 Defendants, Front Groups and KOLs functioned as a continuing unit for the  
17 purpose of implementing the Opioid Marketing Enterprise's scheme and common  
18 purpose, and each agreed to take actions to hide the scheme and continue its  
19 existence.

20 489. At all relevant times, the Front Groups were aware of the RICO  
21 Marketing Defendants' conduct, were knowing and willing participants in that  
22 conduct, and reaped benefits from that conduct. Each Front Group also knew, but  
23 did not disclose, that the other Front Groups were engaged in the same scheme, to  
24 the detriment of consumers, prescribers, and The County. But for the Opioid  
25 Marketing Enterprise's unlawful fraud, the Front Groups would have had  
26 incentive to disclose the deceit by the RICO Marketing Defendants and the Opioid  
27 Marketing Enterprise to their members and constituents. By failing to disclose  
28

1 this information, Front Groups perpetuated the Opioid Marketing Enterprise's  
2 scheme and common purpose, and reaped substantial benefits.

3                   **3. The KOLs**

4                 490. Similarly, each of the RICO Marketing Defendants financed,  
5 supported, utilized and relied on the same KOLs by paying, financing, supporting,  
6 managing, directing, or overseeing, and/or relying on their work. On Information  
7 and belief, the RICO Marketing Defendants cultivated this small circle of doctors  
8 solely because they favored the aggressive treatment of chronic pain with opioids.

9                 491. The RICO Marketing Defendants and the Opioid Marketing  
10 Enterprise relied on their KOLs to serve as part of their speakers bureaus and to  
11 attend programs with speakers bureaus. The RICO Marketing Defendants graded  
12 their KOLs on performance, post-program sales, and product usage. Furthermore,  
13 the RICO Marketing Defendants expected their KOLs to stay "on message," and  
14 obtained agreements from them, in writing, that "all slides must be presented in  
15 their entirety and without alterations . . . and in sequence."

16                 492. The RICO Marketing Defendants' KOLs have been at the center of  
17 the Opioid Marketing Enterprise's marketing efforts, presenting the false  
18 appearance of unbiased and reliable medical research supporting the broad use of  
19 opioid therapy for chronic pain. As described in more detail below, the KOLs  
20 have written, consulted, edited, and lent their names to books and articles, and  
21 given speeches, and CMEs supporting chronic opioid therapy. They have served  
22 on committees that developed treatment guidelines that strongly encourage the use  
23 of opioids to treat chronic pain (even while acknowledging the lack of evidence in  
24 support of that position) and on the boards of the pro-opioid Front Groups  
25 identified above.

26                 493. The RICO Marketing Defendants and KOLS all had systematic  
27 connections and interpersonal relationships, as described below, through the  
28 KOLs receipt of payments from the RICO Marketing Defendants and Front

1 Groups, the KOLs' authoring, publishing, speaking, and educating on behalf of  
 2 the RICO Marketing Defendants, and their leadership roles and participation in  
 3 the activities of the Front Groups, which were in turn financed by the RICO  
 4 Marketing Defendants.

5       494. The systematic contacts and interpersonal relationships of the KOLs  
 6 with the RICO Marketing Defendants and Front Groups are described below:

7       495. Dr. Russell Portenoy – Dr. Portenoy was one of the main KOLs that  
 8 the RICO Marketing Defendants identified and promoted to further the common  
 9 purpose of the Opioid Marketing Enterprise. Dr. Portenoy received research  
 10 support, consulting fees, and honoraria from the RICO Defendants, and was a paid  
 11 consultant to various RICO Marketing Defendants. Dr. Portenoy was  
 12 instrumental in opening the door for the regular use of opioids to treat chronic  
 13 pain. Dr. Portenoy is credited as one of the authors on a primary pillar of the  
 14 RICO Marketing Defendants' misrepresentation regarding the risks and benefits  
 15 of opioid use.<sup>236</sup> Dr. Portenoy had financial relationships with at least a dozen  
 16 pharmaceutical companies, most of which produced prescription opioids.<sup>237</sup>

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18       236 In 1986, the medical journal Pain, which would eventually become the official  
 19 journal of the American Pain Society ("APS"), published an article by Portenoy  
 20 and Foley summarizing the results of a "study" of 38 chronic non-cancer pain  
 21 patients who had been treated with opioid painkillers. Portenoy and Foley  
 22 concluded that, for non-cancer pain, opioids "can be safely and effectively  
 23 prescribed to selected patients with relatively little risk of producing the  
 24 maladaptive behaviors which define opioid abuse." However, their study was  
 25 neither scientific nor did it meet the rigorous standards commonly used to evaluate  
 26 the validity and strength of such studies in the medical community. For instance,  
 27 there was no placebo control group, and the results were retroactive (asking  
 28 patients to describe prior experiences with opioid treatment rather than less biased,  
 in-the-moment reports). The authors themselves advised caution, stating that the  
 drugs should be used as an "alternative therapy" and recognizing that longer term  
 studies of patients on opioids would have to be performed. None were. See Russell  
 K. Portenoy & Kathleen M. Foley, *Chronic use of opioid analgesics in non-*  
*malignant pain: report of 38 cases*, 25(2) Pain 171-86 (May 1986).

237 Anna Lembke, Drug Dealer, MD: How Doctors Were Duped, Patients Got  
 Hooked, and Why It's So Hard to Stop, (Johns Hopkins University Press 2016), at  
 59 (citing Barry Meier, Pain Killer: A "Wonder" Drug's Trail of Addiction and  
 Death (St. Martin's Press, 1st Ed 2003).

1           496. In exchange for the payments he received from the RICO Marketing  
 2 Defendants, Dr. Portenoy is credited as one of the authors on a primary pillar of  
 3 the RICO Marketing Defendants' misrepresentation regarding the risks and  
 4 benefits of opioids.<sup>238</sup> Dr. Portenoy, published, spoke, consulted, appeared in  
 5 advertisements and on television broadcasts, and traveled the country to travel the  
 6 country to promote more liberal prescribing for many types of pain and conduct  
 7 continuing medical education ("CME") seminars sponsored by the RICO  
 8 Marketing Defendants and Front Groups.

9           497. Dr. Portenoy was also a critical component of the RICO Marketing  
 10 Defendants' control over their Front Groups, and the Front Groups support of the  
 11 Opioid Marketing Enterprise's common purpose. Specifically, Dr. Portenoy sat as  
 12 a Director on the board of the APF. He was also the President of the APS.

13           498. In a 2011 interview released by Physicians for Responsible Opioid  
 14 Prescribing, Dr. Portenoy admitted that his earlier work relied on evidence that  
 15 was not "real" and left real evidence behind, all in furtherance of the Opioid  
 16 Marketing Enterprise's common purpose:

17           I gave so many lectures to primary care audiences in which the Porter  
 18 and Jick article was just one piece of data that I would then cite, and I  
 19 would cite six, seven, maybe ten different avenues of thought or  
 20 avenues of evidence, none of which represented real evidence, and yet  
 what I was trying to do was to create a narrative so that the primary

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21           <sup>238</sup> In 1986, the medical journal Pain, which would eventually become the official  
 22 journal of the American Pain Society ("APS"), published an article by Portenoy  
 23 and Foley summarizing the results of a "study" of 38 chronic non-cancer pain  
 24 patients who had been treated with opioid painkillers. Portenoy and Foley  
 25 concluded that, for non-cancer pain, opioids "can be safely and effectively  
 26 prescribed to selected patients with relatively little risk of producing the  
 27 maladaptive behaviors which define opioid abuse." However, their study was  
 28 neither scientific nor did it meet the rigorous standards commonly used to evaluate  
 the validity and strength of such studies in the medical community. For instance,  
 there was no placebo control group, and the results were retroactive (asking  
 patients to describe prior experiences with opioid treatment rather than less biased,  
 in-the-moment reports). The authors themselves advised caution, stating that the  
 drugs should be used as an "alternative therapy" and recognizing that longer term  
 studies of patients on opioids would have to be performed. None were. See Russell  
 K. Portenoy & Kathleen M. Foley, *Chronic use of opioid analgesics in non-*  
*malignant pain: report of 38 cases*, 25(2) Pain 171-86 (May 1986).

1                   care audience would look at this information in [total] and feel more  
 2                   comfortable about opioids in a way they hadn't before. In essence this  
 3                   was education to destigmatize [opioids], and because the primary goal  
 4                   was to destigmatize, we often left evidence behind.<sup>239</sup>

5                  499. Dr. Lynn Webster – Dr. Webster was a critical component of the  
 6                  Opioid Marketing Enterprise, including advocating the RICO Marketing  
 7                  Defendants' fraudulent messages regarding prescription opioids and had  
 8                  systematic contacts and personal relationships with the RICO Marketing  
 9                  Defendants and the Front Groups.

10                 500. Dr. Webster was the co-founder and Chief Medical Director of an  
 11                 otherwise unknown pain clinic in Salt Lake City, Utah (Lifetree Clinical  
 12                 Research), who went on to become one of the RICO Marketing Defendants' main  
 13                 KOLs. Dr. Webster was the President of American Academy of Pain Medicine  
 14                 ("AAPM") in 2013. He is a Senior Editor of Pain Medicine, the same journal that  
 15                 published Endo special advertising supplements touting Opana ER. Dr. Webster  
 16                 was the author of numerous CMEs sponsored by Cephalon, Endo, and Purdue. At  
 17                 the same time, Dr. Webster was receiving significant funding from the RICO  
 18                 Marketing Defendants (including nearly \$2 million from Cephalon alone).

19                 501. During a portion of his time as a KOL, Dr. Webster was under  
 20                 investigation for overprescribing by the U.S. Department of Justice's Drug  
 21                 Enforcement Agency, which raided his clinic in 2010. Although the investigation  
 22                 was closed without charges in 2014, more than twenty (20) of Dr. Webster's  
 23                 former patients at the Lifetree Clinic have died of opioid overdoses.

24                 502. Dr. Webster created and promoted the Opioid Risk Tool, a five  
 25                 question, one-minute screening tool relying on patient self-reports that purportedly  
 26                 allows doctors to manage the risk that their patients will become addicted to or  
 27                 abuse opioids. The claimed ability to pre-sort patients likely to become addicted is

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28                 <sup>239</sup> Andrew Kolodny, *Opioids for Chronic Pain: Addiction is NOT Rare*, YouTube  
 29                 (Oct. 30, 2011),  
 30                 <https://www.youtube.com/watch?v=DgyuBWN9D4w&feature=youtu.be>.

1 an important tool in giving doctors confidence to prescribe opioids long-term, and,  
 2 for this reason, references to screening appear in various industry-supported  
 3 guidelines. Versions of Dr. Webster's Opioid Risk Tool appear on, or are linked  
 4 to, websites run by Endo, Janssen, and Purdue.

5       503. Dr. Webster is also credited as one of the leading proponents of  
 6 "pseudoaddiction" that the RICO Marketing Defendants, Front Groups and KOLs  
 7 disseminated as part of the common purpose of the Opioid Marketing Enterprise.

8       504. Plaintiff The County is informed and believes that in exchange for  
 9 the payments he received from the RICO Marketing Defendants, Dr. Webster  
 10 published, spoke, consulted, appeared in advertisements and on television  
 11 broadcasts, and traveled the country to promote more liberal prescribing of  
 12 opioids for many types of pain and conduct CME seminars sponsored by the  
 13 RICO Marketing Defendants and Front Groups.

14       505. Like Dr. Portenoy, Dr. Webster later reversed his opinion and  
 15 disavowed his previous work on and opinions regarding pseudoaddiction.  
 16 Specifically, Dr. Webster acknowledged that "[pseudoaddiction] obviously  
 17 became too much of an excuse to give patients more medication."<sup>240</sup>

18       506. Dr. Perry Fine – Dr. Webster was a critical component of the Opioid  
 19 Marketing Enterprise, including advocating the RICO Marketing Defendants'  
 20 fraudulent messages regarding prescription opioids and had systematic contacts  
 21 and personal relationships with the RICO Marketing Defendants and the Front  
 22 Groups.

23       507. Dr. Fine was originally a doctor practicing in Utah, who received  
 24 support from the RICO Marketing Defendants, including Janssen, Cephalon,  
 25 Endo, and Purdue. Dr. Fine's ties to the RICO Marketing Defendants have been  
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27       240 John Fauber, *Painkiller Boom Fueled by Networking*, Milwaukee Wisc. J.  
 28 Sentinel, Feb. 18, 2012,  
<http://archive.jsonline.com/watchdog/watchdogreports/painkiller-boom-fueled-by-networking-dp3p2rn-139609053.html>.

1 well documented.<sup>241</sup> He has authored articles and testified in court cases and  
 2 before state and federal committees, and he served as president of the AAPM, and  
 3 argued against legislation restricting high-dose opioid prescription for non-cancer  
 4 patients. Multiple videos featured Fine delivering educational talks about  
 5 prescription opioids. He even testified in a trial that the 1,500 pills a month  
 6 prescribed to celebrity Anna Nicole Smith for pain did not make her an addict  
 7 before her death.<sup>242</sup> He has also acknowledged having failed to disclose numerous  
 8 conflicts of interest.

9       508. Dr. Fine was also a critical component of the RICO Marketing  
 10 Defendants' control over their Front Groups, and the Front Groups support of the  
 11 Opioid Marketing Enterprise's common purpose. Specifically, Dr. Fine served on  
 12 the Board of Directors of APF and served as the President of the AAPM in 2011.

13       509. Plaintiff The County is informed and believes that in exchange for  
 14 the payments he received from the RICO Marketing Defendants, Dr. Fine  
 15 published, spoke, consulted, appeared in advertisements and on television  
 16 broadcasts, and traveled the country to promote more liberal prescribing of  
 17 opioids for many types of pain and conduct CME seminars sponsored by the  
 18 RICO Marketing Defendants and Front Groups.

19       510. Dr. Scott M. Fishman – Dr. Fishman was a critical component of the  
 20 Opioid Marketing Enterprise, including advocating the RICO Marketing  
 21 Defendants' fraudulent messages regarding prescription opioids and had  
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25       <sup>241</sup> Tracy Weber & Charles Ornstein, *Two Leaders in Pain Treatment Have Long*  
 26 *Ties to Drug Industry*, ProPublica (Dec. 23, 2011, 2:14 PM),  
<https://www.propublica.org/article/two-leaders-in-pain-treatment-have-long-ties-to-drug-industry>

27       <sup>242</sup> Linda Deutsch, *Doctor: 1,500 pills don't prove Smith was addicted*, Seattle  
 28 Times (Sept. 22, 2010, 5:16 PM),  
<http://www.seattletimes.com/entertainment/doctor-1500-pills-dont-prove-smithwas-addicted/>.

1 systematic contacts and personal relationships with the RICO Marketing  
 2 Defendants and the Front Groups.

3       511. Although Dr. Fishman did not receive direct financial payments from  
 4 the RICO Marketing Defendants, his ties to the opioid drug industry are legion.<sup>243</sup>

5       512. As Dr. Fishman's personal biography indicates, he is critical  
 6 component of the RICO Marketing Defendants' control over their Front Groups,  
 7 and the Front Groups support of the Opioid Marketing Enterprise's common  
 8 purpose. Specifically, Dr. Fishman is an "internationally recognized expert on  
 9 pain and pain management" who has served in "numerous leadership roles with  
 10 the goal to alleviate pain."<sup>244</sup> Dr. Fishman's roles in the pain industry include  
 11 "past president of the American Academy of Pain Medicine [AAPM], past  
 12 chairman of the board of directors of the American Pain Foundation [APF], and  
 13 past board member of the American Pain Society [APS]."<sup>245</sup> Dr. Fishman is also  
 14 "the immediate past chair and current member of the Pain Care Coalition of the  
 15 American Society of Anesthesiologists, American Pain Society, and Academy of  
 16 Pain Medicine."<sup>246</sup> Dr. Fishman's leadership positions within the central core of  
 17 the RICO Marketing Defendants' Front Groups was a direct result of his  
 18 participation in the Opioid Marketing Enterprise and agreement to cooperate with  
 19 the RICO Marketing Defendants' pattern of racketeering activity.

20       513. Plaintiff The County is informed and believes that in exchange for  
 21 the payments he received from the RICO Marketing Defendants, Dr. Fishman  
 22 published, spoke, consulted, appeared in advertisements and on television  
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25       <sup>243</sup> Scott M. Fishman, M.D., Professor, U.C. Davis Health, Center for Advancing  
 26 Pain Relief,  
[https://www.ucdmc.ucdavis.edu/advancingpainrelief/our\\_team/Scott\\_Fishman.htm](https://www.ucdmc.ucdavis.edu/advancingpainrelief/our_team/Scott_Fishman.htm)  
 1 (accessed on February 28, 2018).

27       <sup>244</sup> *Id.*

28       <sup>245</sup> *Id.*

29       <sup>246</sup> *Id.*

1 broadcasts, and traveled the country to promote more liberal prescribing of  
2 opioids for many types of pain and conduct CME seminars sponsored by the  
3 RICO Marketing Defendants and Front Groups.

4       514. There was regular communication between each of the RICO  
5 Marketing Defendants, Front Groups and KOLs, in which information was shared,  
6 misrepresentations are coordinated, and payments were exchanged. Typically, the  
7 coordination, communication and payment occurred, and continues to occur,  
8 through the use of the wires and mail in which the RICO Marketing Defendants,  
9 Front Groups, and KOLs share information regarding overcoming objections and  
10 resistance to the use of opioids for chronic pain. The RICO Marketing  
11 Defendants, Front Groups and KOLs functioned as a continuing unit for the  
12 purpose of implementing the Opioid Marketing Enterprise's scheme and common  
13 purpose, and each agreed to take actions to hide the scheme and continue its  
14 existence.

15       515. At all relevant times, the KOLs were aware of the RICO Marketing  
16 Defendants' conduct, were knowing and willing participants in that conduct, and  
17 reaped benefits from that conduct. The RICO Marketing Defendants selected  
18 KOLs solely because they favored the aggressive treatment of chronic pain with  
19 opioids. The RICO Marketing Defendants' support helped the KOLs become  
20 respected industry experts. And, as they rose to prominence, the KOLs falsely  
21 touted the benefits of using opioids to treat chronic pain, repaying the RICO  
22 Marketing Defendants by advancing their marketing goals. The KOLs also knew,  
23 but did not disclose, that the other KOLS and Front Groups were engaged in the  
24 same scheme, to the detriment of consumers, prescribers, and The County. But  
25 for the Opioid Marketing Enterprise's unlawful conduct, the KOLs would have  
26 had incentive to disclose the deceit by the RICO Marketing Defendants and the  
27 Opioid Marketing Enterprise, and to protect their patients and the patients of other  
28 physicians. By failing to disclose this information, KOLs furthered the Opioid

1 Marketing Enterprise's scheme and common purpose, and reaped substantial  
2 benefits.

3       516. As public scrutiny and media coverage focused on how opioids  
4 ravaged communities in California and throughout the United States, the Front  
5 Groups and KOLS did not challenge the RICO Marketing Defendants'  
6 misrepresentations, seek to correct their previous misrepresentations, terminate  
7 their role in the Opioid Marketing Enterprise, nor disclose publicly that the risks  
8 of using opioids for chronic pain outweighed their benefits and were not supported  
9 by medically acceptable evidence.

10      517. The RICO Marketing Defendants, Front Groups and KOLs engaged  
11 in certain discrete categories of activities in furtherance of the common purpose of  
12 the Opioid Marketing Enterprise. As reported in *Fueling an Epidemic*, the Opioid  
13 Marketing Enterprise's conduct in furtherance of the common purpose of the  
14 Opioid Marketing Enterprise involved: (1) misrepresentations regarding the risk  
15 of addiction and safe use of prescription opioids for long-term chronic pain; (2)  
16 lobbying to defeat measures to restrict over-prescription; (3) efforts to criticize or  
17 undermine CDC guidelines; and (4) efforts to limit prescriber accountability. The  
18 misrepresentations made in these publications are described in the following  
19 section.

20      518. Efforts to Minimize the Risk of Addiction and Promote Opioid Use  
21 As Safe for Long-Term Treatment of Chronic Pain – Members of the Opioid  
22 Marketing Enterprise furthered the common purpose of the enterprise by  
23 publishing and disseminating statements that minimized the risk of addiction and  
24 misrepresented the safety of using prescription opioids for long-term treatment of  
25 chronic, non-acute, and non-cancer pain. The categories of misrepresentations

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1 made by the Opioid Marketing Enterprise and the RICO Defendants included the  
 2 following:<sup>247</sup>

- 3     • The Use of Opioids for the Treatment of Chronic Pain: A Consensus  
     4         Statement From the American Academy of Pain Medicine and the  
     5         American Pain Society, 13 Clinical J. Pain 6 (1997). The “landmark  
     6         consensus” was published by the AAPM and APS. Dr. Portenoy was the  
     7         sole consultant. A member of Purdue’s speaker bureau authored the  
     8         consensus.
- 9     • *Model Guidelines for the Use of Controlled Substances for the Treatment of*  
 10         *Pain* (1998, 2004, 2007).<sup>248</sup> These guidelines, originally published by the  
 11         FSMB in collaboration with RICO Defendants, advocated that opioids were  
 12         “essential” and that “misunderstanding of addiction” contributed to  
 13         undertreated pain.
- 14     • Oxycontin: Balancing Risks and Benefits: Hearing of the S. Comm. on  
 15         Health, Education, Labor and Pensions, Testimony by John D. Giglio,  
 16         M.A., J.D., Executive Direction of the APF (2002).<sup>249</sup>
- 17     • *The Management of Persistent Pain in Older Persons* (2002). These  
 18         guidelines were published by AGS with substantial funding from Endo,  
 19         Purdue and Janssen.
- 20     • *Overview of Management Options* (2003, 2007, 2010, and 2013).<sup>250</sup> This  
 21         CME was edited by Dr. Portenoy, sponsored by Purdue, and published by

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23     <sup>247</sup> As noted below, the earliest misrepresentations disseminated by the RICO  
 24         Defendants and the Opioid Marketing Enterprise began in 1997 and has continued  
 25         unabated since that time. Therefore, this list is alleged as fully and completely as  
 26         possible.

27     <sup>248</sup> *Model Policy for the Use of Controlled Substances for the Treatment of Pain*,  
 28         Federation of State Medical Boards of the United States, May 2004,  
            [https://www.ihs.gov/painmanagement/includes/themes/newihstheme/display\\_objects/documents/modelpolicytreatmentpain.pdf](https://www.ihs.gov/painmanagement/includes/themes/newihstheme/display_objects/documents/modelpolicytreatmentpain.pdf) (last accessed on March 9, 2018).

29     <sup>249</sup> Oxycontin: Balancing Risks and Benefits: Hearing of the S. Comm. on Health,  
 30         Education, Labor and Pensions, Testimony by John D. Giglio, M.A., J.D.,  
 31         Executive Direction of the APF (2002.)

1                   the American Medical Association. It taught that opioids, unlike non-  
 2                   prescription pain medication are safe at high doses.

- 3                   • *Understanding Your Pain: Taking Oral Opioid Analgesics* (2004).<sup>251</sup> This  
 4                   article, published by Endo Pharmaceuticals advocated that withdrawal and  
 5                   needing to take higher dosages are not signs of addiction.
- 6                   • Interview by Paula Moyer with Scott M. Fishman, M.D. (2005). Dr.  
 7                   Fishman advocated that “the risks of addiction are . . . small and can be  
 8                   managed.”<sup>252</sup>
- 9                   • Open-label study of fentanyl effervescent buccal tablets in patients with  
 10                  chronic pain and breakthrough pain: interim safety and tolerability results  
 11                  (2006).<sup>253</sup> Dr. Webster gave this CME, sponsored by Cephalon, that  
 12                  misrepresented that opioids were safe for the treatment of non-cancer pain.
- 13                  • *Treatment Options: A Guide for People Living With Pain* (2007). This  
 14                  document was published by the APF and sponsored by Cephalon and  
 15                  Purdue.<sup>254</sup>

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 18                  <sup>250</sup> Portenoy, et al., *Overview of Management Options*, <https://cme.ama-assn.org/activity/1296783/detail.aspx>. On information and belief, this CME was  
 19                  published by the American Medical Association in 2003, 2007, 2010, and 2013.

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 21                  <sup>251</sup> Margo McCaffery & Chris Pasero, *Understanding Your Pain: Taking Oral Opioid Analgesics*, Endo Pharmaceuticals (2004),  
<https://www.yumpu.com/en/document/view/35479278/understanding-your-pain-taking-oral-opioid-analgesics> (last accessed March 8, 2018).

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 23                  <sup>252</sup> Interview by Paula Moyer with Scott M. Fishman, M.D., Professor of Anesthesiology and Pain Medicine, Chief of the Division of Pain Medicine, Univ. of Cal., Davis (2005), available at <http://www.medscape.org/viewarticle/500829>.

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 25                  <sup>253</sup> Hale ME, Webster LR, Peppin JF, Messina J. Open-label study of fentanyl effervescent buccal tablets in patients with chronic pain and breakthrough pain: interim safety and tolerability results. Program and abstracts of the annual meeting of the American Academy of Pain Medicine; February 22-25, 2006; San Diego, California. Abstract 120. Published with permission of Lynn R. Webster, MD, [https://www.medscape.org/viewarticle/524538\\_2](https://www.medscape.org/viewarticle/524538_2) (accessed on March 6, 2018).

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 27                  <sup>254</sup> Am. Pain Found., *Treatment Options: A Guide for People Living in Pain* (2007) [hereinafter APF, *Treatment Options*],  
<https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf> (last accessed on March 8, 2018).

- 1     • *Responsible Opioid Prescribing: A Physician's Guide* (2007).<sup>255</sup> This  
2         book, authored by Dr. Fishman was financed by the FSMB with funding  
3         from Cephalon, Endo and Purdue.
- 4     • *Avoiding Opioid Abuse While Managing Pain* (2007).<sup>256</sup> This book, co-  
5         authored by Dr. Webster, misrepresented that for prescribers facing signs of  
6         aberrant behavior, increasing the dose in “most cases . . . should be a  
7         clinician’s first response.”
- 8     • *Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version  
9         1.0-SF* (2008).<sup>257</sup> This screening tool was published by the National  
10         Institutes of Health with support from Endo through an educational grant,  
11         and advocated that most patients are able to successfully remain on long-  
12         term opioid therapy without significant problems.
- 13     • *Case Challenges in Pain Management: Opioid Therapy for Chronic Pain*  
14         (2007).<sup>258</sup> This article, sponsored by Endo, misrepresented that opioids are  
15         a highly effective class of analgesic drugs.
- 16     • *Opioid-Based Management of Persistent and Breakthrough Pain* (2008).<sup>259</sup>  
17         This document was written by Dr. Fine and sponsored by an educational  
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20     <sup>255</sup> Scott M. Fishman, *Responsible Opioid Prescribing: A Physician's Guide*, 8-9  
21         (Waterford Life Sciences 2007).

22     <sup>256</sup> Lynn Webster & Beth Dove, *Avoiding Opioid Abuse While Managing Pain*  
23         (2007).

24     <sup>257</sup> *Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0-SF*, PainEdu.org, 2008, <https://www.nhms.org/sites/default/files/Pdfs/SOAPP-5.pdf> (last accessed on March 8, 2018).

25     <sup>258</sup> Charles E. Argoff, *Case Challenges in Pain Management: Opioid Therapy for Chronic Pain*, Pain Med. News,  
26         [https://www.painmedicinewebs.com/download/BtoB\\_Opana\\_WM.pdf](https://www.painmedicinewebs.com/download/BtoB_Opana_WM.pdf) (last visited on March 8, 2018).

27     <sup>259</sup> Perry G Fine, MD, et al. *Opioid-Based Management of Persistent and Breakthrough Pain*, Pain Medicine News,  
28         <https://www.yumpu.com/en/document/view/11409251/opioid-based-management-of-persistent-and-breakthrough-pain> (accessed on February 27, 2018).

1 grant from Cephalon. Dr. Fine advocated for the prescription of rapid onset  
 2 opioids “in patients with non-cancer pain.”

- 3 • *Optimizing Opioid Treatment for Breakthrough Pain* (2008).<sup>260</sup> Dr.  
 4 Webster presented an online seminar (webinar) sponsored by Cephalon, that  
 5 misrepresented that non-opioid analgesics and combination opioids  
 6 containing non-opioids are less effective because of dose limitations.
- 7 • *Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non-*  
 8 *Cancer Pain* (2009).<sup>261</sup> These guidelines were published by AAPM and  
 9 APS. Fourteen of the twenty-one panel members, including Dr. Portenoy  
 10 and Dr. Fine, received support from the RICO Defendants.
- 11 • *Pharmacological Management of Persistent Pain in Older Persons*  
 12 (2009).<sup>262</sup> These guidelines were published by AGS, with substantial  
 13 funding from Endo, Purdue, and Janssen, updated the 2002 guidelines and  
 14 misrepresented that the risks of addiction are exceedingly low.
- 15 • Iraq War Veteran Amputee, Pain Advocate and New Author Release Exit  
 16 Wounds: A Survival Guide to Pain Management for Returning Veterans  
 17 and Their Families,<sup>263</sup> American Pain Foundation, 2009. This article was  
 18 published in 2009 and sponsored by Purdue.

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 21 <sup>260</sup> Lynn Webster, *Optimizing Opioid Treatment for Breakthrough Pain*, Medscape,  
 22 [http://www.medscape.org/viewarticle/563417\\_6](http://www.medscape.org/viewarticle/563417_6) (last visited Dec. 11, 2017).

22 <sup>261</sup> Roger Chou et al., Clinical Guidelines for the Use of Chronic Opioid Therapy in  
 23 Chronic Non-Cancer Pain, 10 J. Pain 113 (2009).

23 <sup>262</sup> *Pharmacological Management of Persistent Pain in Older Persons*, 57 J. Am.  
 24 Geriatrics Soc'y 1331, 1339, 1342 (2009), available at  
<https://www.nhqualitycampaign.org/files/AmericanGeriatricSociety-PainGuidelines2009.pdf> (last accessed on March 9, 2018).

25 <sup>263</sup> Iraq War Veteran Amputee, Pain Advocate and New Author Release Exit  
 26 Wounds: A Survival Guide to Pain Management for Returning Veterans and Their  
 27 Families, Coalition for Iraq + Afghanistan Veterans,  
<http://web.archive.org/web/20100308224011/http://coalitionforveterans.org:80/2009/10/iraq-war-veteran-amputee-pain-advocate-and-new-author-releases-exit-wounds-a-survival-guide-to-pain-management-for-returning-veterans-and-their-families> (last visited March 1, 2018)

- 1     • *Finding Relief: Pain Management for Older Adults*, (2009).<sup>264</sup> This article  
2         was a collaboration between the American Geriatrics Society, AAPM and  
3         Janssen.
- 4     • Good Morning America (2010). Dr. Portenoy appeared on Good Morning  
5         America and stated that “Addiction, when treating pain, is distinctly  
6         uncommon.”<sup>265</sup>
- 7     • *A Policymaker’s Guide to Understanding Pain & Its Management, American Pain Foundation* (2011).<sup>266</sup> APF published this document, that  
8         was sponsored by Purdue, which argued that the notion of strong pain  
9         leading to addiction is a common misconception.
- 10    • *Managing Patient’s Opioid Use: Balancing the Need and the Risk* (2011).<sup>267</sup> Dr. Webster presented a webinar, sponsored by Purdue, that  
11         misrepresented the ability to use risk screen tools, urine samples and patient  
12         agreements to prevent overuse and overdose death.
- 13    • *Safe and Effective Opioid Rotation* (2012).<sup>268</sup> This CME, delivered by Dr.  
14         Fine, that is also available online, advocated for the safe and non-addictive  
15         use of opioids to treat cancer and non-cancer patients over a person’s  
16         “lifetime.”

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21    <sup>264</sup> Finding Relief, Pain Management for Older Adults, (2009).

22    <sup>265</sup> Good Morning America (ABC television broadcast Aug. 30, 2010).

23    <sup>266</sup> *A Policymaker’s Guide to Understanding Pain & Its Management, American Pain Foundation* (2011) at

24    5, <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf> (last visited March 6, 2018).

25    <sup>267</sup> See, *Managing Patient’s Opioid Use: Balancing the Need and the Risk, Emerging Solutions in Pain* [http://www.emergingsolutionsinpain.com/ce-education/opioid-management?option=com\\_continued&view=frontmatter&Itemid=303&course=209](http://www.emergingsolutionsinpain.com/ce-education/opioid-management?option=com_continued&view=frontmatter&Itemid=303&course=209) (last visited Aug. 22, 2017).

26    <sup>268</sup> Perry A. Fine, *Safe and Effective Opioid Rotation*, YouTube (Nov. 8, 2012),  
27         [https://www.youtube.com/watch?v=\\_G3II9yqgXI](https://www.youtube.com/watch?v=_G3II9yqgXI).

- 1     • *Pain: Opioid Facts* (2012).<sup>269</sup> This document was published online on  
 2       Endo's website painknowledge.org and advocated for the use of opioids and  
 3       downplayed the risk of addiction, even for people with a history of  
 4       addiction and opioid use, and supported the concept of pseudoaddiction.

5           519. Efforts to Criticize or Undermine CDC Guidelines – Members of the  
 6       Opioid Marketing Enterprise criticized or undermined the CDC Guidelines which  
 7       represented “an important step – and perhaps the first major step from the federal  
 8       government – toward limiting opioid prescriptions for chronic pain.” The  
 9       following are examples of the actions taken by Opioid Marketing Enterprise  
 10      members to prevent restriction on over-prescription:

- 11       • Several Front Groups, including the U.S. Pain Foundation, and the AAPM  
 12       criticized the draft guidelines in 2015, arguing that the “CDC slides  
 13       presented on Wednesday were not transparent relative to process and failed  
 14       to disclose the names, affiliation, and conflicts of interest of the individuals  
 15       who participated in the construction of these guidelines.”<sup>270</sup>
- 16       • The AAPM criticized the prescribing guidelines in 2016, through its  
 17       immediate past president, stating “that the CDC guideline makes  
 18       disproportionately strong recommendations based upon a narrowly selected  
 19       portion of the available clinical evidence.”<sup>271</sup>

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 23       <sup>269</sup> *Pain: Opioid Facts*,  
 24       [http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patient/pdf/Patient%20Education%20b380\\_b385%20%20pf%20opioid.pdf](http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patient/pdf/Patient%20Education%20b380_b385%20%20pf%20opioid.pdf) (last visited March 6, 2018).

25       <sup>270</sup> Pat Anson, *Chronic Pain Group Blasts CDC for Opioid Guidelines*, Pain News  
 26       Networks, <https://www.painnewsnetwork.org/stories/2015/9/22/chronic-pain-groups-blast-cdc-for-opioid-guidelines> (last accessed on March 8, 2018).

27       <sup>271</sup> Practical Pain Management, Responses and Criticisms Over New CDC Opioid  
 28       Prescribing Guidelines  
 29       (<https://www.practicalpainmanagement.com/resources/news-and-research/responses-criticisms-over-new-cdc-opioid-prescribing-guidelines>)  
 30       (accessed Sept. 28, 2017).

1       520. In each of the actions performed by members of the Opioid  
2 Marketing Enterprise, described above, the members of the Opioid Marketing  
3 Enterprise made branded and unbranded marketing claims about prescription  
4 opioids that misrepresented prescription opioids as non-addictive and safe for use  
5 as identified in following section.

6                                  **4. Members of the Opioid Marketing Enterprise**  
7                                  **Furthered the Common Purpose by Making**  
8                                  **Misrepresentations.**

9       521. The RICO Marketing Defendants, Front Groups and KOLs  
10 participated in the conduct of the Opioid Marketing Enterprise and shared in the  
11 common purpose of marketing opioids for chronic pain through a pattern of  
12 racketeering activity (including multiple instances of mail and wire fraud) by  
13 knowingly making material misrepresentations or omissions to California  
14 prescribers, consumers, the general public, regulators and The County. All of the  
15 misrepresentations made by members of the Opioid Marketing Enterprise  
16 furthered the common purpose of the Enterprise.

17       522. Members of the Opioid Marketing Enterprise, including the RICO  
18 Marketing Defendants, Front Groups and KOLs made multiple unbranded  
19 marketing misrepresentations about the benefits and risks of opioid use, in  
20 furtherance of the Opioid Marketing Enterprise's common purpose, as follows:

21       523. Members of the Opioid Marketing Enterprise minimized the risks of  
22 addiction and/or construed opioids as non-addictive:

- 23              • AAMP and APS endorsed the use of opioids to treat chronic pain and  
24 claimed that the risk of a patients' addiction to opioids was low.<sup>272</sup>

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<sup>272</sup> The Use of Opioids for the Treatment of Chronic Pain: A Consensus Statement  
28 From the American Academy of Pain Medicine and the American Pain Society, 13  
Clinical J. Pain 6 (1997).

- “[O]pioids are safe and effective, and only in rare cases lead to addiction.”<sup>273</sup>
  - “[T]he risks of addiction are . . . small and can be managed.”<sup>274</sup>

**Medscape:** Controversy surrounds both the undertreatment and overtreatment of pain. Overtreatment of pain obviously involves the fear of causing or perpetuating opioid drug dependency. What recommendations can you give to primary care physicians who are reluctant to prescribe opioids, either as adjuncts or primary agents for pain control, because of these fears?

**Dr. Fishman:** It used to be that when you had a patient with pain and you were worried about giving him or her a drug that may be abusable or may cause addiction, the safest thing to do was nothing, as though doing nothing would have no risks in and of itself. We know that the risks of addiction are there, but they are small and can be managed. The AAPM is going to be at the forefront, educating

- Represented that calling opioids “‘narcotics’ reinforces myths and misunderstandings as it places emphasis on their potential abuse rather than on the importance of their use as pain medicines.”<sup>275</sup>
  - “Addiction, when treating pain, is distinctly uncommon. If a person does not have a history, a personal history, of substance abuse, and does not have a history in the family of substance abuse, and does not have a very major psychiatric disorder, most doctors can feel very assured that that person is not going to become addicted.”<sup>276</sup>

## **OPIOID ANALGESICS (NARCOTICS)**

Opioid analgesics are another important class of medications that are very effective pain relievers. As mentioned before, they may also be called "narcotics." Unfortunately, this term is used by law enforcement to refer to drugs that are abused. Cocaine and heroin are called narcotics even though they are very different kinds of drugs. Calling opioid analgesics "narcotics" reinforces myths and misunderstandings as it places emphasis on their potential abuse rather than on the importance of their use as pain medicines. In the pain treatment world, the word opioid is used when speaking about this class of medications.

<sup>273</sup> *Oxycontin: Balancing Risks and Benefits: Hearing of the S. Comm. on Health, Education, Labor and Pensions*, 107th Cong. 2 (Feb. 12, 2002) (testimony of John D. Giglio, M.A., J.D., Executive Director, American Pain Foundation), <https://www.help.senate.gov/imo/media/doc/Giglio.pdf>.

<sup>274</sup> Interview by Paula Moyer with Scott M. Fishman, M.D., Professor of Anesthesiology and Pain Medicine, Chief of the Division of Pain Medicine, Univ. of Cal., Davis (2005), available at <http://www.medscape.org/viewarticle/500829>.

<sup>275</sup> APF, *Treatment Options*, <https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf> (last accessed on March 8, 2018).

<sup>276</sup> Good Morning America (ABC television broadcast Aug. 30, 2010).

- 1     • The risk of addiction is manageable for patients regardless of past abuse  
2         histories.<sup>277</sup>
- 3     • “[T]he likelihood that the treatment of pain using an opioid drug which is  
4         prescribed by a doctor will lead to addiction is extremely low.”<sup>278</sup>
- 5     • Patients might experience withdrawal symptoms associated with physical  
6         dependence as they decrease their dose, “[b]ut unlike actual addicts, such  
7         individuals, if they resume their opioid use, will only take enough  
8         medication to alleviate their pain.”<sup>279</sup>
- 9     • The notion that “strong pain medication leads to addiction” is a “common  
10         misconception.”<sup>280</sup>

## SOME COMMON MISCONCEPTIONS ABOUT PAIN

13     **Use of strong pain medication leads to addiction.** Many people living with  
14         pain, and even some health care practitioners, falsely believe that opioid pain  
15         medicines are universally addictive. As with any medication, there are risks, but  
16         these risks can be managed when these medicines are properly prescribed and  
               taken as directed. For more information about safety issues related to opioids  
               and other pain therapies, visit [www.painsafe.org](http://www.painsafe.org).

20 \_\_\_\_\_  
21     <sup>277</sup> Roger Chou et al., Clinical Guidelines for the Use of Chronic Opioid Therapy in  
Chronic Non-Cancer Pain, 10 J. Pain 113 (2009).

22     <sup>278</sup> Thomas Catan and Evan Perez, *A Pain-Drug Champion Has Second Thoughts*,  
The Wall Street Journal (Dec. 17, 2012),  
<https://www.wsj.com/articles/SB10001424127887324478304578173342657044604>.

23     <sup>279</sup> Brief Amici Curiae of American Pain Foundation, National Foundation for the  
Treatment of Pain, and The Ohio Pain Initiative, in Support of  
Defendants/Appellants, Howland v. Purdue Pharma, L.P., et al., Appeal No. CA  
2002 09 0220 (Butler Co., Ohio 12th Court of Appeals, Dec. 23, 2002),  
<https://ia801005.us.archive.org/23/items/279014-howland-apf-amicus/279014-howland-apf-amicus.pdf>.

24     <sup>280</sup> A Policymaker’s Guide to Understanding Pain & Its Management, American  
Pain Foundation (2011) at 5, <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf> (last visited March 6, 2018).

- “Addiction to an opioid would mean that your pain has gone away but you still take the medicine regularly when you don’t need it for pain, maybe just to escape your problems.”<sup>281</sup>

*How can I be sure I'm not addicted?*

- ◆ Addiction to an opioid would mean that your pain has gone away but you still take the medicine regularly when you don't need it for pain, maybe just to escape from your problems.
  - ◆ Ask yourself: Would I want to take this medicine if my pain went away? If you answer no, you are taking opioids for the right reasons—to relieve your pain and improve your function. You are not addicted.

- Even for patients assessed to have a risk of abuse, “it does not mean that opioid use will become problematic or that opioids are contraindicated.”<sup>282</sup>

### **WILL I BECOME ADDICTED TO OPIOIDS?**

This is a key issue for both you and your doctor to discuss. In general, people who have no history of drug abuse, including tobacco, and use their opioid medication as directed will probably not become addicted. However, patients who misuse or abuse opioids can become addicted to them, so openly discussing your concerns with your doctor is important. People who are addicted to opioids crave the "unusually happy" effect the drug has on them (a "buzz" or "high") and will continue to use the drug even though it harms them.



<sup>281</sup> Margo McCaffery & Chris Pasero, *Understanding Your Pain: Taking Oral Opioid Analgesics*, Endo Pharmaceuticals (2004), <https://www.yumpu.com/en/document/view/35479278/understanding-your-pain-taking-oral-opioid-analgesics> (last accessed March 8, 2018).

<sup>282</sup> Scott M. Fishman, *Responsible Opioid Prescribing: A Physician's Guide*, 8-9 (Waterford Life Sciences 2007).

- 1     • [P]eople who have no history of drug abuse, including tobacco, and use  
2       their opioid medication as directed will probably not become addicted.”<sup>283</sup>
- 3     • “A history of addiction would not rule out the use of opioid pain  
4       relievers.”<sup>284</sup>



A history of addiction would not rule out the use of opioid pain relievers.

- 9     • APF published exit wounds, wherein it represented that “[l]ong experience  
10      with opioids shows that people who are not predisposed to addiction are  
11      very unlikely to become addicted to opioid pain medications.”<sup>285</sup>

#### Iraq War Veteran Amputee, Pain Advocate and New Author Releases Exit Wounds: A Survival Guide to Pain Management for Returning Veterans and Their Families



*“It’s now four years since I lay in the dirt, near death, on the side of the road in Fallujah. I’m grateful for all the things I have, and proud of all I’ve accomplished. In the end though, I don’t measure how far I’ve come by goals achieved, or academic degrees earned, or running trophies won. For me, what counts is that pain no longer rules my life.” – Derek McGinnis*

The American Pain Foundation (APF) announces the release of Iraq War Veteran and Pain Advocate Derek McGinnis’ first book, *Exit Wounds: A Survival Guide to Pain Management for Returning Veterans and Their Families*. Written in collaboration with nationally renowned pain experts, the release date of September 21 for *Exit Wounds* coincided with September’s designation as Pain Awareness Month.

- 20     • Patients rarely become addicted to prescribed opioids.<sup>286</sup>

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<sup>283</sup> *Pain: Opioid Facts*,  
23     <http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patiente>  
24     nted/pdf/Patient%20Education%20b380\_b385%20%20pf%20opioid.pdf (last  
visited March 6, 2018).

25     <sup>284</sup> *Id.*

26     <sup>285</sup> Iraq War Veteran Amputee, Pain Advocate and New Author Release Exit  
27     Wounds: A Survival Guide to Pain Management for Returning Veterans and Their  
28     Families, Coalition for Iraq + Afghanistan Veterans,  
   <http://web.archive.org/web/20100308224011/http://coalitionforveterans.org:80/2009/10/iraq-war-veteran-amputee-pain-advocate-and-new-author-releases-exit-wounds-a-survival-guide-to-pain-management-for-returning-veterans-and-their-families> (last visited March 1, 2018).

- 1     • Concern about patients becoming addicted reflects widespread failure to  
 2       appreciate the distinction between “(1) *tolerance* – the body’s tendency to  
 3       become accustomed to a substance so that, over time, a larger amount is  
 4       needed to produce the same physical effect (pain relief) and *physical*  
 5       *dependence* – the state defined by the experience of adverse symptoms if a  
 6       drug is abruptly withdrawn . . . each of which is common with pain  
 7       patients” . . . “and, on the other hand, (2) the psychological and behavioral  
 8       patterns – an unhealthy craving for, compulsive use of, and unhealthy  
 9       fixation – that characterize *addiction*.<sup>287</sup>
- 10    • Evidence establishes that the risk of drug addiction (historically the  
 11      principal *medical* justification for withholding or limiting opioids) is far  
 12      less substantial than long and widely assumed.<sup>288</sup>
- 13      the addiction. Although the risks are exceedingly low in  
 14      older patients with no current or past history of substance  
 15      abuse, it is impossible to identify every patient who will  
 16      abuse or divert prescribed opioids.<sup>117</sup> Therefore, many cli-  
 17      nicians have adopted a Universal Precautions approach to  
 18      pain management.<sup>118</sup> This paradigm stresses that every pa-
- 19      • The “risks [of addiction] are exceedingly low in older patients with no  
 20      current or past history of substance abuse.”<sup>289</sup>

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 22    <sup>286</sup> Brief of Amici the American Pain Foundation, the National Pain Foundation,  
 23      and the National Foundation for the Treatment of Pain, 2005 WL 2405247, \*9  
 24      (citing Portenoy, Russell, et al., *Acute and Chronic Pain*, in *COMPREHENSIVE*  
 25      *TEXTBOOK OF SUBSTANCE ABUSE*, 863-903 (Lowinson et al. eds., 4th ed.  
 26      2005), *United States v. Hurwitz*, 459 F.3d 463 (2006) (citing Portenoy et. al.,  
 27      *Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases*,  
 28      PAIN, Vol. 25, 171-186, (1986)).

25    <sup>287</sup> Brief of Amici Russel K. Portenoy, et al., 2005 WL 2405249, *United States v.*  
 26      *Hurwitz*, 459 F.3d 463 (2006) (emphasis in original).

27    <sup>288</sup> *Id.* and sources cited at note 9.

28    <sup>289</sup> *Pharmacological Management of Persistent Pain in Older Persons*, 57 J. Am.  
 29      Geriatrics Soc'y 1331, 1339, 1342 (2009), available at  
 30      <https://www.nhqualitycampaign.org/files/AmericanGeriatricSociety-PainGuidelines2009.pdf> (last accessed on March 9, 2018).

1       524. Members of the Opioid Marketing Enterprise advocated that opioids  
2 were safe and effective for long-term treatment of chronic, non-acute and non-  
3 cancer pain:

- 4       • “Opioids are an essential option for treating *moderate* to severe pain  
5              associated with surgery or trauma. They may also be an important part of  
6              the management of persistent pain unrelated to cancer.”<sup>290</sup>

7              **Clinical uses**

8              Opioids are an essential option for treating moderate to severe pain associated with  
9              surgery or trauma, and for pain related to cancer. They may also be an important part of  
10             the management of persistent pain unrelated to cancer. These medicines block pain

- 11       • Opioids were a safe and effective treatment for pain as part of a  
12              physicians’ treatment guidelines.<sup>291</sup>
- 13       • The “small risk of abuse does not justify the withholding of these highly  
14              effective analgesics from chronic pain patients.”<sup>292</sup>
- 15       • Opioids, unlike some non-prescription pain medications, are safe at high  
16              doses.<sup>293</sup>
- 17       • Falsely representing “recent findings suggesting that most patients are able  
18              to successfully remain on long-term opioid therapy without significant  
19              problems.”<sup>294</sup>

20       

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21       <sup>290</sup> APF, *Treatment Options*,  
22              <https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf>.

23       <sup>291</sup> Roger Chou et al., Clinical Guidelines for the Use of Chronic Opioid Therapy in  
24              Chronic Non-Cancer Pain, 10 J. Pain 113 (2009).

25       <sup>292</sup> Brief Amici Curiae of American Pain Foundation, National Foundation for the  
26              Treatment of Pain, and The Ohio Pain Initiative, in Support of  
27              Defendants/Appellants, Howland v. Purdue Pharma, L.P., et al., Appeal No. CA  
28              2002 09 0220 (Butler Co., Ohio 12th Court of Appeals, Dec. 23, 2002),  
            <https://ia801005.us.archive.org/23/items/279014-howland-apf-amicus/279014-howland-apf-amicus.pdf>.

29       <sup>293</sup> Portenoy, et al., *Overview of Management Options*, <https://cme.ama-assn.org/activity/1296783/detail.aspx>. On information and belief, this CME was published in 2003, 2007, 2010, and 2013.

30       <sup>294</sup> *Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0-SF*, PainEdu.org, 2008, <https://www.nhms.org/sites/default/files/Pdfs/SOAPP-5.pdf> (last accessed on March 8, 2018).

- 1     • Opioid therapy is an appropriate treatment for chronic, non-cancer pain and  
2         integral to good medical practice.<sup>295</sup>
- 3     • Even for patients assessed to have a risk of abuse, “it does not mean that  
4         opioid use will become problematic or that opioids are contraindicated.”<sup>296</sup>
- 5     • Opioid therapy is an appropriate treatment for chronic, non-cancer pain and  
6         integral to good medical practice.<sup>297</sup>
- 7     • Broadly classifying pain syndromes as “either cancer- or non-cancer-related  
8         has limited utility,” and recommended dispensing rapid onset opioids “in  
9         patients with non-cancer pain.”<sup>298</sup>

10           The data suggest that FEBT is safe and well tolerated in opioid-tolerant patients  
11          with chronic noncancer pain. There was no respiratory depression, and a low  
12          incidence of treatment-related adverse events was reported. Thirty-five patients  
13          (37%) reported having at least 1 adverse event, the most common of which were  
14          nausea (7%) and dizziness (5%).

- 15     • Opioids are safe and well-tolerated in patients with chronic pain and break  
16         through pain.<sup>299</sup>
- 17     • Non-opioid analgesics and combination opioids containing non-opioids  
18         such as aspirin and acetaminophen are less effective than opioids because of  
19         dose limitations on non-opioids.<sup>300</sup>

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20           <sup>295</sup> Scott M. Fishman, *Responsible Opioid Prescribing: A Physician’s Guide*, 8-9  
21          (Waterford Life Sciences 2007).

22           <sup>296</sup> *Id.*

23           <sup>297</sup> Scott M. Fishman, *Responsible Opioid Prescribing: A Physician’s Guide*, 8-9 (Waterford Life  
24          Sciences 2007).

25           <sup>298</sup> Perry G Fine, MD, et al. *Opioid-Based Management of Persistent and*  
26          *Breakthrough Pain*, Pain Medicine News,  
27          [https://www.yumpu.com/en/document/view/11409251/opioid-based-management-](https://www.yumpu.com/en/document/view/11409251/opioid-based-management-of-persistent-and-breakthrough-pain)  
28          [of-persistent-and-breakthrough-pain](https://www.yumpu.com/en/document/view/11409251/opioid-based-management-of-persistent-and-breakthrough-pain) (accessed on February 27, 2018).

29           <sup>299</sup> Hale ME, Webster LR, Peppin JF, Messina J. Open-label study of fentanyl  
30          effervescent buccal tablets in patients with chronic pain and breakthrough pain:  
31          interim safety and tolerability results. Program and abstracts of the annual meeting  
32          of the American Academy of Pain Medicine; February 22-25, 2006; San Diego,  
33          California. Abstract 120. Published with permission of Lynn R. Webster, MD,  
34          [https://www.medscape.org/viewarticle/524538\\_2](https://www.medscape.org/viewarticle/524538_2) (accessed on March 6, 2018).

adverse events. Furthermore, although nonopioid analgesics, such as acetaminophen and NSAIDs/COX-2 inhibitors, are effective for nociceptive pain, their use in BTP is likewise restricted by dose-limiting toxicities, an onset of action that is delayed by 30 minutes or more, a long duration of action that could augment sedation and other side effects of the agent used for the baseline pain, and fears about renal and cardiovascular complications. Agents that combine an SAO, such as hydrocodone plus acetaminophen, aspirin, or ibuprofen, also are limited by potential adverse events and ceiling effects from the nonopioid component.

- Opioids can safely alleviate chronic pain unresponsive to other medication.<sup>301</sup>
- Medical organization and government-sponsored clinical guidelines support and encourage opioid treatment for chronic pain.<sup>302</sup>
- Respiratory depression, even at extremely high levels, does not occur in the context of appropriate clinical treatment.<sup>303</sup>
- There is no “ceiling dose” for opioids.<sup>304</sup>
- Opioid analgesics are the most effective way to treat pain of moderate to severe intensity and often the only treatment that provides significant relief.<sup>305</sup>
- “Opioid rotations” (switching from one opioid to another) not only for cancer patients, but also for non-cancer patients, may need to occur four or five times over a person’s “lifetime” to manage pain.<sup>306</sup>

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<sup>300</sup> Lynn Webster, *Optimizing Opioid Treatment for Breakthrough Pain*, Medscape, [http://www.medscape.org/viewarticle/563417\\_6](http://www.medscape.org/viewarticle/563417_6) (last visited Dec. 11, 2017).

<sup>301</sup> Brief of Amici the American Pain Foundation, the National Pain Foundation, and the National Foundation for the Treatment of Pain, 2005 WL 2405247, \*8, *United States v. Hurwitz*, 459 F.3d 463 (2006) (citing Portenoy et. al, *Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases*, PAIN, Vol. 25, 171-186, (1986)).

<sup>302</sup> *Id.* at \*8, and sources cited in note 11.

<sup>303</sup> *Id.*

<sup>304</sup> *Id.*

<sup>305</sup> Brief of Amici Russel K. Portenoy, et al., 2005 WL 2405249, *United States v. Hurwitz*, 459 F.3d 463.

- 1     • Opioids represent a highly effective . . . class of analgesic medications for  
2         controlling both chronic and acute pain. The phenomenon of tolerance to  
3         opioids – the gradual waning of relief at a given dose – and fears of abuse,  
4         diversion, and misuse of these medications by patients have led many  
5         clinicians to be wary of prescribing these drugs, and/or to restrict dosages to  
6         levels that may be insufficient to provide meaningful relief.<sup>307</sup>

7             Opioids represent a highly effective but controversial and often misunder-  
8         stood class of analgesic medications for controlling both chronic and acute  
9         pain. The phenomenon of tolerance to opioids—the gradual waning of relief at  
10         a given dose—and fears of abuse, diversion, and misuse of these medications  
11         by patients have led many clinicians to be wary of prescribing these drugs,  
12         and/or to restrict dosages to levels that may be insufficient to provide mean-  
13         ingful relief.<sup>3</sup>

14         525. Members of the Opioid Marketing Enterprise created and  
15         championed the concept of “pseudoaddiction,” advocating that signs of addiction  
16         were actually pseudoaddiction that required prescribing additional opioids:

- 17     • Patients might experience withdrawal symptoms associated with physical  
18         dependence as they decrease their dose, “[b]ut unlike actual addicts, such  
19         individuals, if they resume their opioid use, will only take enough  
20         medication to alleviate their pain.”<sup>308</sup>

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22         

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<sup>306</sup> Perry A. Fine, *Safe and Effective Opioid Rotation*, YouTube (Nov. 8, 2012),  
23         [https://www.youtube.com/watch?v=\\_G3II9yqgXI](https://www.youtube.com/watch?v=_G3II9yqgXI).

24         <sup>307</sup> Charles E. Argoff, *Case Challenges in Pain Management: Opioid Therapy for*  
25         *Chronic Pain*, Pain Med. News, 2007,  
26         [https://www.painmedicinewebs.com/download/BtoB\\_Opana\\_WM.pdf](https://www.painmedicinewebs.com/download/BtoB_Opana_WM.pdf) (last visited  
27         on March 8, 2018).

28         <sup>308</sup> Brief Amici Curiae of American Pain Foundation, National Foundation for the  
Treatment of Pain, and The Ohio Pain Initiative, in Support of  
Defendants/Appellants, Howland v. Purdue Pharma, L.P., et al., Appeal No. CA  
2002 09 0220 (Butler Co., Ohio 12th Court of Appeals, Dec. 23, 2002),  
<https://ia801005.us.archive.org/23/items/279014-howland-apf-amicus/279014-howland-apf-amicus.pdf>.

- “Addiction **IS NOT** when a person develops ‘withdrawal’ (such as abdominal cramping or sweating) after the medicine is stopped or the dose is reduced by a large amount. . . . Addiction also **IS NOT** what happens when some people taking opioids need to take a higher dose after a period of time in order for it to continue to relieve their pain. This normal ‘tolerance’ to opioid medications doesn’t affect everyone who takes them and does not, by itself, imply addiction.”<sup>309</sup>

## WHAT SHOULD I KNOW ABOUT OPIOIDS AND ADDICTION?

You or your family may have questions about addiction. It is important to understand what addiction is. Addiction **IS** a chronic brain disease that can occur in some people exposed to certain substances such as alcohol, cocaine, and opioids. Taking opioids for pain relief is not addiction. People addicted to opioids crave the opioid and use it regularly for reasons other than pain relief.

Addiction **IS NOT** when a person develops "withdrawal" (such as abdominal cramping or sweating) after the medicine is stopped quickly or the dose is reduced by a large amount. Your doctor will avoid stopping your medication suddenly by slowly reducing the amount of opioid you take before the medicine is completely stopped. Addiction also **IS NOT** what happens when some people taking opioids need to take a higher dose after a period of time in order for it to continue to relieve their pain. This normal "tolerance" to opioid medications doesn't affect everyone who takes them and does not, by itself, imply addiction. If tolerance does occur, it does not mean you will "run out" of pain relief. Your dose can be adjusted or another medicine can be prescribed.

<sup>309</sup> Margo McCaffery & Chris Pasero, *Understanding Your Pain: Taking Oral Opioid Analgesics*, Endo Pharmaceuticals (2004), [http://www.thblack.com/links/RSD/Understand\\_Pain\\_Opioid\\_Analgesics.pdf](http://www.thblack.com/links/RSD/Understand_Pain_Opioid_Analgesics.pdf) (emphasis in original) (last accessed on March 9, 2018).

- “Addiction to an opioid would mean that your pain has gone away but you still take the medicine regularly when you don’t need it for pain, maybe just to escape your problems.”<sup>310</sup>

*How can I be sure I'm not addicted?*

- ◆ Addiction to an opioid would mean that your pain has gone away but you still take the medicine regularly when you don't need it for pain, maybe just to escape from your problems.
  - ◆ Ask yourself: Would I want to take this medicine if my pain went away? If you answer no, you are taking opioids for the right reasons—to relieve your pain and improve your function. You are not addicted.

- Behaviors such as “[r]equesting [drugs] by name,” “[d]emanding or manipulative behavior,” “[o]btaining drugs from more than one physician,” and “[h]oarding opioids,” are all really signs of pseudoaddiction, rather than genuine addiction.”<sup>311</sup>
  - “Sometimes people behave as if they are addicted, when they are really in need of more medication.”<sup>312</sup>

310 *Id.*

<sup>311</sup> Scott M. Fishman, Responsible Opioid Prescribing: A Physician's Guide, 8-9 (Waterford Life Sciences 2007).

<sup>312</sup> Pain: Opioid Facts, [http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patient/pdf/Patient%20Education%20b380\\_b385%20%20pf%20opiod.pdf](http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patient/pdf/Patient%20Education%20b380_b385%20%20pf%20opiod.pdf) (last visited March 6, 2018).

- 1           • **ADDICTION** - A craving that  
2           drives a person to take an  
3           opioid even though it causes  
4           harm. This is a problem that  
5           needs immediate treatment.  
6           This happens to some patients  
7           who use opioids.

8           Sometimes people behave as  
9           if they are addicted, when they  
10          are really in need of more  
11          medication. This can be treated  
12          with higher doses of medicine.

- 13         • For prescribers facing signs of aberrant behavior, increasing the does “in  
14          most cases . . . should be the clinician’s first response.”<sup>313</sup>

15         526. Members of the Opioid Marketing Enterprise advocated that long-  
16          term use of prescription opioids would improve function, including but not limited  
17          to, psychological health, and health-related quality of life:

- 18         • When opioids are managed, properly prescribed and taken as directed, they  
19          are effective in improving daily function, psychological health and health-  
20          related quality of life.<sup>314</sup>
- 21         • Opioid therapy to relieve pain and improve function is a legitimate medical  
22          practice for acute and chronic pain of both cancer and non-cancer origins.<sup>315</sup>

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25         <sup>313</sup> Lynn Webster & Beth Dove, Avoiding Opioid Abuse While Managing Pain  
26         (2007).

27         <sup>314</sup> A Policymaker’s Guide to Understanding Pain & Its Management, American  
28         Pain Foundation (2011) at 5, <http://s3.documentcloud.org/documents/277603/apf-policymakers-guide.pdf> (last visited March 6, 2018).

29         <sup>315</sup> Scott M. Fishman, Responsible Opioid Prescribing: A Physician’s Guide, 8-9  
30         (Waterford Life Sciences 2007); Scott M. Fishman, *Responsible Opioid  
31         Prescribing: A Clinician’s Guide*, 10-11 (2d ed. 2012).

1 Because of their long history of  
2 use, the clinical profile of opioids  
3 has been very well characterized.  
4 Multiple clinical studies have  
5 shown that long-acting opioids, in  
6 particular, are effective in  
7 improving:  
8

- Daily function
- Psychological health
- Overall health-related quality of  
life for people with chronic  
pain<sup>12</sup>

- 9 • “[Y]our level of function should improve, you may find you are now able to  
10 participate in activities of daily living, such as work and hobbies, that you  
11 were not able to enjoy when your pain was worse.”<sup>316</sup>
- 12 • “The goal of opioid therapy is to . . . improve your function.”<sup>317</sup>

13       *The goal of opioid therapy is to control pain and improve your function.*

- 15
- 16 • The “goal” for chronic pain patients is to “improve effectiveness which is  
17 different from efficacy and safety.”<sup>318</sup>

24       

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25<sup>316</sup> Plaintiffs are informed and believe that this misrepresentation was made on the  
website painknowledge.org.

26<sup>317</sup> *Pain: Opioid Facts*,  
27 [http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patiente/pdf/Patient%20Education%20b380\\_b385%20%20pf%20opiod.pdf](http://web.archive.org/web/20120112051109/http://www.painknowledge.org/patiente/pdf/Patient%20Education%20b380_b385%20%20pf%20opiod.pdf) (last visited March 6, 2018).

28<sup>318</sup> Perry A. Fine, *Safe and Effective Opioid Rotation*, YouTube (Nov. 8, 2012),  
[https://www.youtube.com/watch?v=\\_G3II9yqgXI](https://www.youtube.com/watch?v=_G3II9yqgXI).



•  
12        527. Members of the Opioid Marketing Enterprise represented that  
13 screening questions and professional guidelines would help curb addiction and  
14 potential abuse:

- 15        • Screening questions and professional guidelines will “easily and  
16        efficiently” allow physicians to manage risk and “minimize the potential for  
17        abuse.”<sup>319</sup>
- 18        • Risk screening tools, urine testing, and patient agreements are a way to  
19        prevent “overuse of prescriptions” and “overdose deaths.”<sup>320</sup>
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25        <sup>319</sup> Scott M. Fishman, *Responsible Opioid Prescribing: A Physician’s Guide*, 8-9  
26        (Waterford Life Sciences 2007).

27        <sup>320</sup> See, *Managing Patient’s Opioid Use: Balancing the Need and the Risk*,  
28        Emerging Solutions in Pain [http://www.emergingsolutionsinpain.com/ce-education/opioid-management?option=com\\_continued&view=frontmatter&Itemid=303&course=209](http://www.emergingsolutionsinpain.com/ce-education/opioid-management?option=com_continued&view=frontmatter&Itemid=303&course=209) (last visited Aug. 22, 2017).

1                   **Program Overview**

2                   Compliance with regulatory and policy-driven authorities mandates improvement in the treatment of patients on chronic opioid therapy (COT) to  
3                   ensure that the best possible care is provided to pain patients while minimizing potential risk of inappropriate use. Participants of this activity will  
4                   be able to evaluate current issues in appropriate patient selection and management of chronic pain patients treated with COT including a review  
5                   of the most current Risk Evaluation and Mitigation Strategies (REMS) requirements, updates in the development of novel delivery systems and  
6                   the practical application of assessment tools to assist in their daily practice.

- 7                   • The risks of addiction and abuse can be managed by doctors and evaluated  
8                   with “tools.”<sup>321</sup>

9                   528. In addition to the unbranded marketing misrepresentations made by  
10                  members of the Opioid Marketing Enterprise, the RICO Marketing Defendants  
11                  made misrepresentations in their branded marketing activities. The RICO  
12                  Marketing Defendants’ branded marketing misrepresentations furthered the  
13                  common purpose of the Opioid Marketing Enterprise because they advanced the  
14                  common messages of the Opioid Marketing Enterprise. For example:

15                  529. The RICO Marketing Defendants misrepresented that opioids were  
16                  non-addictive or posed less risk of addiction or abuse:

- 17                  • Purdue:
  - 18                   ○ “Fear of addiction is exaggerated.”<sup>322</sup>

26                  

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27                  <sup>321</sup> Perry A. Fine, *Safe and Effective Opioid Rotation*, YouTube (Nov. 8, 2012),  
28                  [https://www.youtube.com/watch?v=\\_G3II9yqgXI](https://www.youtube.com/watch?v=_G3II9yqgXI).

27                  <sup>322</sup> Harriet Ryan, et al., “*You Want A Description of Hell?*” *OxyContin’s 12-Hour Problem*, L.A. Times (May 5, 2016), <http://documents.latimes.com/oxycontin-press-release-1996/> (hereinafter “Ryan, Description of Hell”).

1                   The fear of addiction is exaggerated.

2                   One cause of patient resistance to appropriate pain treatment – the  
3                   fear of addiction – is largely unfounded. According to Dr. Max,  
4                   "Experts agree that most pain caused by surgery or cancer can be  
5                   relieved, primarily by carefully adjusting the dose of opioid  
6                   (narcotic) pain reliever to each patient's need, and that there is very  
7                   little risk of addiction from the proper uses of these drugs for pain  
8                   relief."

9                   Paul D. Goldenheim, M.D., Vice President of **Purdue Pharma L.P.** in  
10                  Norwalk, Connecticut, agrees with this assessment. "Proper use of  
11                  medication is an essential weapon in the battle against persistent  
12                  pain. But too often fear, misinformation and poor communication stand  
13                  in the way of their legitimate use."

- 14                  o "[W]e've discovered that the simplicity and convenience of twice-  
15                  daily dosing also enhances patient compliance with their doctor's  
16                  instructions."<sup>323</sup>

17                  taking tablets every four to six hours. Moreover, we've discovered that  
18                  the simplicity and convenience of twice-daily dosing also enhances

19                  [https://www.nexis.com/results/enhdocview.do?docLinkInd=true&ersKey=23\\_T23962617276&format=GNBF](https://www.nexis.com/results/enhdocview.do?docLinkInd=true&ersKey=23_T23962617276&format=GNBF)

20                  

21                  1/27/2016

22                  patient compliance with their doctor's instructions."

- 23                  o Long-acting, extended release formulations are safe and "less prone"  
24                  to abuse by patients and addiction.<sup>324</sup>
- 25                  o OxyContin is safe and non-addictive when using extended release  
26                  formulations, and appropriate for use in non-cancer patients.<sup>325</sup>

27                  

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<sup>323</sup> *Id.*

28                  <sup>324</sup> Barry Meier, *In Guilty Plea, OxyContin Maker to Pay \$600 Million*, N.Y.  
29                  Times (May 10, 2007), <http://www.nytimes.com/2007/05/10/business/11drug-web.html> (hereinafter "Meier, Guilty Plea").

30                  <sup>325</sup> Charles Ornstein & Tracy Weber, *American Pain Foundation Shuts Down as  
31                  Senators Launch Investigation of Prescription Narcotics*, ProPublica (May 8,  
32                  2012, 8:57 PM),  
33                  [http://www.opb.org/news/article/america\\_pain\\_foundation\\_shuts\\_down\\_as\\_senato](http://www.opb.org/news/article/america_pain_foundation_shuts_down_as_senato)

- 1       ○ Consistently minimizing the risk of addiction in the use of opioids for
- 2              the treatment of chronic non-cancer-related pain.<sup>326</sup>
- 3       ○ OxyContin is virtually non-addicting.<sup>327</sup>
- 4       ○ “Assur[ing] doctors – repeatedly and without evidence – that ‘fewer
- 5              than one percent’ of patients who took OxyContin became
- 6              addicted.”<sup>328</sup>



- 17       ○ OxyContin was addiction resistant and had “abuse-deterrent
- 18              properties.”<sup>329</sup>
- 19       ○ Misrepresented the risk of addiction using misleading and inaccurate
- 20              promotions of OxyContin that were unsupported by science.<sup>330</sup>

22       rs\_launch\_investigation\_of\_prescription\_narcotics/ (hereinafter “Ornstein,  
23              American Pain Foundation”).

24       <sup>326</sup> Art Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99(2) Am. J. Pub. Health 221-27 (Feb. 2009) (hereinafter, “Van Zee, Promotion and Marketing”).

25       <sup>327</sup> Patrick Keefe, *The Family that Built an Empire of Pain*, New Yorker (Oct. 30, 2017), <https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain>

26       <sup>328</sup> *Id.*; see also “I got my life back,” OxyContin Promotional Video, 1998, <https://www.youtube.com/watch?v=Er78Dj5hyeI> (last accessed on March 8, 2018).

27       <sup>329</sup> *Id.*

- 1           ○ It was more difficult to extract the oxycodone from an OxyContin  
2           tablet for intravenous abuse.<sup>331</sup>
- 3           ○ OxyContin created fewer chances for addiction than immediate-  
4           release opioids.<sup>332</sup>
- 5           ○ OxyContin had fewer “peak and trough” effects than immediate-  
6           release opioids resulting in less euphoria and less potential for abuse  
7           than short-acting opioids.<sup>333</sup>
- 8           ○ Patients could abruptly stop opioid therapy without experiencing  
9           withdrawal symptoms, and patients who took OxyContin would not  
10          develop tolerance.<sup>334</sup>
- 11          ○ OxyContin did not cause a “buzz,” caused less euphoria, had less  
12          addiction potential, had less abuse potential, was less likely to be  
13          diverted than immediate-release opioids, and could be used to “weed  
14          out” addicts and drug seekers.<sup>335</sup>
- 15          ○ Purdue published a prescriber and law enforcement education  
16          pamphlet in 2011 entitled *Providing Relief, Preventing Abuse*, which  
17          under the heading, “Indications of Possible Drug Abuse,” shows  
18          pictures of the stigmata of injecting or snorting opioids—skin  
19          popping, track marks, and perforated nasal septa. In fact, opioid  
20          addicts who resort to these extremes are uncommon; the far more  
21          typical reality is patients who become dependent and addicted

23          <sup>330</sup> Press Release, U.S. Attorney for the Western District of Virginia, Statement of  
24          United States Attorney John Brownlee on the Guilty Plea of the Purdue Frederick  
25          Company and Its Executives for Illegally Misbranding OxyContin (May 10, 2007),  
<https://assets.documentcloud.org/documents/279028/purdue-guilty-plea.pdf>.

26          <sup>331</sup> *Id.*

27          <sup>332</sup> *Id.*

28          <sup>333</sup> *Id.*

<sup>334</sup> *Id.*

<sup>335</sup> *Id.*

1 through oral use. Thus, these misrepresentations wrongly reassured  
 2 doctors that as long as they do not observe those signs, they need not  
 3 worry that their patients are abusing or addicted to opioids.

- 4           ○ Purdue sponsored APF's *A Policymaker's Guide to Understanding*  
           5           *Pain & Its Management*, which inaccurately claimed that less than  
           6           1% of children prescribed opioids will become addicted. This  
           7           publication is still available online. This publication also asserted that  
           8           pain is undertreated due to "misconceptions about opioid addiction."
- 9           ○ Purdue sponsored APF's *Treatment Options: A Guide for People*  
 10           *Living with Pain* (2007), which asserted that addiction is rare and  
 11           limited to extreme cases of unauthorized dose escalations, obtaining  
 12           opioids from multiple sources, or theft.
- 13           ○ A Purdue-funded study with a Purdue co-author claimed that  
 14           "evidence that the risk of psychological dependence or addiction is  
 15           low in the absence of a history of substance abuse."<sup>336</sup> The study  
 16           relied only on the 1980 Porter-Jick letter to the editor concerning a  
 17           chart review of hospitalized patients, not patients taking Purdue's  
 18           long-acting, take-home opioid. Although the term "low" is not  
 19           defined, the overall presentation suggests the risk is so low as not to  
 20           be a worry.
- 21           ○ Purdue contracted with AGS to produce a CME promoting the 2009  
 22           guidelines for the *Pharmacological Management of Persistent Pain*  
 23           in *Older Persons*. These guidelines falsely claim that "the risks [of  
 24           addiction] are exceedingly low in older patients with no current or  
 25           past history of substance abuse." None of the references in the  
 26

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27           <sup>336</sup> C. Peter N. Watson et al., Controlled-release oxycodone relieves neuropathic  
 28           pain: a randomized controlled trial I painful diabetic neuropathy, 105 Pain 71  
          (2003).

1 guidelines corroborates the claim that elderly patients are less likely  
2 to become addicted to opioids and the claim is, in fact, untrue. Purdue  
3 was aware of the AGS guidelines' content when it agreed to provide  
4 this funding, and AGS drafted the guidelines with the expectation it  
5 would seek drug company funding to promote them after their  
6 completion.

- 7 ○ Purdue sponsored APF's *Exit Wounds* (2009), which counseled  
8 veterans that “[l]ong experience with opioids shows that people who  
9 are not predisposed to addiction are very unlikely to become addicted  
10 to opioid pain medications.” Although the term “very unlikely” is not  
11 defined, the overall presentation suggests it is so low as not to be a  
12 worry.
  - 13 ○ Purdue sales representatives told prescribers that its drugs were  
14 “steady state,” the implication of which was that they did not produce  
15 a rush or euphoric effect, and therefore were less addictive and less  
16 likely to be abused.
  - 17 ○ Purdue sales representatives told prescribers that Butrans has a lower  
18 abuse potential than other drugs because it was essentially  
19 tamperproof and, after a certain point, patients no longer experience a  
20 “buzz” from increased dosage.
  - 21 ○ Advertisements that Purdue sent to prescribers stated that OxyContin  
22 ER was less likely to be favored by addicts, and, therefore, less likely  
23 to be abused or diverted, or result in addiction.
  - 24 ○ In discussions with prescribers, Purdue sales representatives omitted  
25 discussion of addiction risks related to Purdue’s drugs.
- 26 • Janssen:
- 27 ○ **Myth:** Opioid medications are always addictive.

1                   **Fact:** Many studies show that opioids are rarely addictive when used  
2                   properly for the management of chronic pain.<sup>337</sup>

- 3                   ○ **Myth:** Opioid doses have to get bigger over time because the body  
4                   gets used to them.

5                   **Fact:** Unless the underlying cause of your pain gets worse (such as  
6                   with cancer or arthritis), you will probably remain on the same dose  
7                   or need only small increases over time.<sup>338</sup>

- 8                   ○ “[Q]uestions of addiction,” “are often overestimated” because,  
9                   “[a]ccording to clinical opinion polls, true addiction occurs only in a  
10                  small percentage of patients with chronic pain who receive chronic  
11                  opioid analgesics.”<sup>339</sup>

12                  *Other Opioid Analgesic Concerns*

13                  Aside from medical issues related to opioid analgesics, there are nonmedical  
14                  issues that may have an impact on prescribing patterns and patient use of  
15                  these drugs. Practitioners are often concerned about prescribing opioid  
16                  analgesics due to potential legal issues and **questions of addiction**.<sup>15,16</sup> By  
17                  the same token, patients report similar concerns about developing an  
18                  addiction to opioid analgesics.<sup>17</sup> While these concerns are not without some  
19                  merit, it would appear that they are often overestimated. According to clinical  
20                  opinion polls, true addiction occurs only in a small percentage of patients  
21                  with chronic pain who receive chronic opioid analgesics analgesic therapy.<sup>18</sup>

- 22                  ○ Janssen sponsored a patient education guide titled *Finding Relief:*  
23                  *Pain Management for Older Adults* (2009), which its personnel  
24                  reviewed and approved and which its sales force distributed. This  
25                  guide described a “myth” that opioids are addictive, and asserts as  
26                  fact that “[m]any studies show that opioids are rarely addictive when

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27                  <sup>337</sup> Finding Relief, Pain Management for Older Adults, (2009) (emphasis in  
28                  original).

29                  <sup>338</sup> Finding Relief, Pain Management for Older Adults, (2009) (emphasis in  
30                  original).

31                  <sup>339</sup> *Use of Opioid Analgesics in Pain Management*, Prescribe Responsibly,  
32                  <http://www.prescriberesponsibly.com/articles/opioid-pain-management> (last  
33                  visited Dec. 11, 2017).

1 used properly for the management of chronic pain.” Although the  
2 term “rarely” is not defined, the overall presentation suggests the risk  
3 is so low as not to be a worry. The language also implies that as long  
4 as a prescription is given, opioid use is not a problem.

- 5 ○ Janssen contracted with AGS to produce a CME promoting the 2009  
6 guidelines for the *Pharmacological Management of Persistent Pain*  
7 in *Older Persons*. These guidelines falsely claim that “the risks [of  
8 addiction] are exceedingly low in older patients with no current or  
9 past history of substance abuse.” The study supporting this assertion  
10 does not analyze addiction rates by age and, as already noted,  
11 addiction remains a significant risk for elderly patients. Janssen was  
12 aware of the AGS guidelines’ content when it agreed to provide this  
13 funding, and AGS drafted the guidelines with the expectation it  
14 would seek drug company funding to promote them after their  
15 completion.
- 16 ○ Janssen provided grants to APF to distribute *Exit Wounds* (2009) to  
17 veterans, which taught that “[l]ong experience with opioids shows that  
18 people who are not predisposed to addiction are very unlikely to  
19 become addicted to opioid pain medications.” Although the term  
20 “very unlikely” is not defined, the overall presentation suggests the  
21 risk is so low as not to be a worry.
- 22 ○ Janssen currently runs a website, Prescriberesponsibly.com (last  
23 modified July 2, 2015), which claims that concerns about opioid  
24 addiction are “overstated.”
- 25 ○ A June 2009 Nucynta Training module warns Janssen’s sales force  
26 that physicians are reluctant to prescribe controlled substances like  
27 Nucynta, but this reluctance is unfounded because “the risks . . . are  
28 much smaller than commonly believed.”

- 1           ○ Janssen sales representatives told prescribers that its drugs were
- 2           “steady state,” the implication of which was that they did not produce
- 3           a rush or euphoric effect, and therefore were less addictive and less
- 4           likely to be abused.
- 5           ○ Janssen sales representatives told prescribers that Nucynta and
- 6           Nucynta ER were “not opioids,” implying that the risks of addiction
- 7           and other adverse outcomes associated with opioids were not
- 8           applicable to Janssen’s drugs. In truth, however, as set out in
- 9           Nucynta’s FDA-mandated label, Nucynta “contains tapentadol, an
- 10          opioid agonist and Schedule II substance with abuse liability similar
- 11          to other opioid agonists, legal or illicit.”
- 12          ○ Janssen’s sales representatives told prescribers that Nucynta’s unique
- 13          properties eliminated the risk of addiction associated with the drug.
- 14          ○ In discussions with prescribers, Janssen sales representatives omitted
- 15          discussion of addiction risks related to Janssen’s drugs.
- 16          ● Cephalon:
  - 17           ○ Cephalon sponsored and facilitated the development of a guidebook,
  - 18           *Opioid Medications and REMS: A Patient’s Guide*, which claims,
  - 19           among other things, that “patients without a history of abuse or a
  - 20           family history of abuse do not commonly become addicted to
  - 21           opioids.”
  - 22           ○ Cephalon sponsored APF’s *Treatment Options: A Guide for People*
  - 23           *Living with Pain* (2007), which taught that addiction is rare and
  - 24           limited to extreme cases of unauthorized dose escalations, obtaining
  - 25           opioids from multiple sources, or theft.
  - 26           ○ In discussions with prescribers, Cephalon sales representatives
  - 27           omitted any discussion of addiction risks related to Cephalon’s drugs.

- 1     • Endo:
- 2         ○ Opana ER was designed to be crush resistant
- 3         ○ Opana ER was crush and abuse resistant and not addictive.<sup>340</sup>
- 4         ○ “[T]he Reformulated Opana ER as ‘designed to be’ crush
- 5             resistant.”<sup>341</sup>
- 6         ○ “[P]atients treated with prolonged opioid medicines usually do not
- 7             become addicted.”<sup>342</sup>
- 8         ○ Endo trained its sales force in 2012 that use of long-acting opioids
- 9             resulted in increased patient compliance, without any supporting
- 10            evidence.
- 11         ○ Endo’s advertisements for the 2012 reformulation of Opana ER
- 12            claimed it was designed to be crush resistant, in a way that conveyed
- 13            that it was less likely to be abused. This claim was false; the FDA
- 14            warned in a May 10, 2013 letter that there was no evidence Endo’s
- 15            design “would provide a reduction in oral, intranasal or intravenous
- 16            abuse” and Endo’s “post-marketing data submitted are insufficient to
- 17            support any conclusion about the overall or route-specific rates of
- 18            abuse.” Further, Endo instructed its sales representatives to repeat
- 19            this claim about “design,” with the intention of conveying Opana ER
- 20            was less subject to abuse.
- 21
- 22
- 23

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24         <sup>340</sup> *In the Matter of Endo Health Solutions Inc. and Endo Pharmaceuticals Inc.*,  
25            Assurance No. 15-228, Assurance of Discontinuance Under Executive Law  
26            Section 63, Subdivision 15, at 5 (Mar. 1, 2016),  
27            [https://ag.ny.gov/pdfs/Endo\\_AOD\\_030116-Fully\\_Executed.pdf](https://ag.ny.gov/pdfs/Endo_AOD_030116-Fully_Executed.pdf).

28         <sup>341</sup> *Id.* at 6.

29         <sup>342</sup> *In the Matter of Endo Health Solutions Inc. and Endo Pharmaceuticals Inc.*,  
30            Assurance No. 15-228, Assurance of Discontinuance Under Executive Law  
31            Section 63, Subdivision 15, at 5 (Mar. 1, 2016),  
32            [https://ag.ny.gov/pdfs/Endo\\_AOD\\_030116-Fully\\_Executed.pdf](https://ag.ny.gov/pdfs/Endo_AOD_030116-Fully_Executed.pdf).

- 1           ○ Endo sponsored a website, painknowledge.com, through APF and
- 2           NIPC, which claimed in 2009 that: “[p]eople who take opioids as
- 3           prescribed usually do not become addicted.” Although the term
- 4           “usually” is not defined, the overall presentation suggests the risk is
- 5           so low as not to be a worry. The language also implies that as long as
- 6           a prescription is given, opioid use will not become problematic. Endo
- 7           continued to provide funding for this website through 2012, and
- 8           closely tracked unique visitors to it.
- 9           ○ Endo sponsored a website, PainAction.com, which stated “Did you
- 10          know? Most chronic pain patients do not become addicted to the
- 11          opioid medications that are prescribed for them.”
- 12          ○ Endo sponsored CMEs published by APF’s NIPC, of which Endo
- 13          was the sole funder, titled *Persistent Pain in the Older Adult* and
- 14          *Persistent Pain in the Older Patient*. These CMEs claimed that
- 15          opioids used by elderly patients present “possibly less potential for
- 16          abuse than in younger patients[,]” which lacks evidentiary support
- 17          and deceptively minimizes the risk of addiction for elderly patients.
- 18          ○ Endo distributed an education pamphlet with the Endo logo titled
- 19          *Living with Someone with Chronic Pain*, which inaccurately
- 20          minimized the risk of addiction: “Most health care providers who
- 21          treat people with pain agree that most people do not develop an
- 22          addiction problem.”
- 23          ○ Endo distributed a patient education pamphlet edited by key opinion
- 24          leader Dr. Russell Portenoy titled *Understanding Your Pain: Taking*
- 25          *Oral Opioid Analgesics*. It claimed that “[a]ddicts take opioids for
- 26          other reasons [than pain relief], such as unbearable emotional
- 27
- 28

1           problems.” This implies that pain patients prescribed opioids will not  
2           become addicted, which is unsupported and untrue.

- 3           o Endo contracted with AGS to produce a CME promoting the 2009  
4           guidelines for the *Pharmacological Management of Persistent Pain*  
5           in *Older Persons*. These guidelines falsely claim that “the risks [of  
6           addiction] are exceedingly low in older patients with no current or  
7           past history of substance abuse.” None of the references in the  
8           guidelines corroborates the claim that elderly patients are less likely  
9           to become addicted to opioids, and there is no such evidence. Endo  
10          was aware of the AGS guidelines’ content when it agreed to provide  
11          this funding, and AGS drafted the guidelines with the expectation it  
12          would seek drug company funding to promote them after their  
13          completion.
- 14          o Endo sales representatives told prescribers that its drugs were “steady  
15          state,” the implication of which was that they did not produce a rush  
16          or euphoric effect, and therefore were less addictive and less likely to  
17          be abused.
- 18          o Endo provided grants to APF to distribute *Exit Wounds* (2009) to  
19          veterans, which taught that “[l]ong experience with opioids shows  
20          that people who are not predisposed to addiction are very unlikely to  
21          become addicted to opioid pain medications.” Although the term  
22          “very unlikely” is not defined, the overall presentation suggests that  
23          the risk is so low as not to be a worry.
- 24          o In discussions with prescribers, Endo sales representatives omitted  
25          discussion of addiction risks related to Endo’s drugs.

26          530. The RICO Marketing Defendants misrepresented that opioids  
27          improved function and quality of life:

1     • Purdue:

- 2         ◦ “[W]e’ve discovered that the simplicity and convenience of twice-  
3                 daily dosing also enhances patient compliance with their doctor’s  
4                 instructions.”<sup>343</sup>

5  
6                 taking tablets every four to six hours. Moreover, we’ve discovered that  
7                 the simplicity and convenience of twice-daily dosing also enhances

8                 [https://www.nexis.com/results/enhdocview.do?docLinkInd=true&ersKey=23\\_T23962617276&format=GNBF](https://www.nexis.com/results/enhdocview.do?docLinkInd=true&ersKey=23_T23962617276&format=GNBF)

9  
10                 

11                 */27/2016*  
12                 patient compliance with their doctor’s instructions.”

- 13         ◦ Purdue ran a series of advertisements for OxyContin in 2012 in  
14                 medical journals titled “Pain vignettes,” which were case studies  
15                 featuring patients, each with pain conditions persisting over several  
16                 months, recommending OxyContin for each. One such patient,  
17                 “Paul,” is described to be a “54-year-old writer with osteoarthritis of  
18                 the hands,” and the vignettes imply that an OxyContin prescription  
19                 will help him work more effectively.
- 20         ◦ Purdue sponsored APF’s *A Policymaker’s Guide to Understanding*  
21                 *Pain & Its Management*, which inaccurately claimed that “multiple  
22                 clinical studies” have shown that opioids are effective in improving  
23                 daily function, psychological health, and health-related quality of life  
24                 for chronic pain patients.” The sole reference for the functional  
25                 improvement claim noted the absence of long-term studies and  
26                 actually stated: “For functional outcomes, the other analgesics were

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28                 

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<sup>343</sup> Ryan, *Description of Hell*, <http://documents.latimes.com/oxycontin-press-release-1996/>

1 significantly more effective than were opioids.” *The Policymaker’s*  
 2 *Guide* is still available online.

- 3 ○ Purdue sponsored APF’s Treatment Options: A Guide for People  
 4 Living with Pain (2007), which counseled patients that opioids, when  
 5 used properly, “give [pain patients] a quality of life we deserve.”  
 6 APF distributed 17,200 copies in one year alone, according to its  
 7 2007 annual report, and the guide currently is available online.
- 8 ○ Purdue sponsored APF’s *Exit Wounds* (2009), which taught veterans  
 9 that opioid medications “increase your level of functioning.” *Exit*  
 10 *Wounds* also omits warnings of the risk of interactions between  
 11 opioids and benzodiazepines, which would increase fatality risk.  
 12 Benzodiazepines are frequently prescribed to veterans diagnosed with  
 13 post-traumatic stress disorder.
- 14 ○ Purdue sponsored the FSMB’s Responsible Opioid Prescribing  
 15 (2007), which taught that relief of pain itself improved patients’  
 16 function. Responsible Opioid Prescribing explicitly describes  
 17 functional improvement as the goal of a “long-term therapeutic  
 18 treatment course.” Purdue also spent over \$100,000 to support  
 19 distribution of the book.

20 • Janssen:

- 21 ○ Misrepresented that patients experienced “[s]ignificantly reduced  
 22 nighttime awakenings.”<sup>344</sup>
- 23 ○ Misrepresented “[s]ignificant improvement in disability scores as  
 24 measured by the Oswestry Disability Questionnaire and Pain  
 25 Disability Index.”<sup>345</sup>

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27 <sup>344</sup> NDA 19-813 Letter from Spencer Salis, U.S. Food & Drug Administration, to  
 28 Cynthia Chianese, Janssen Pharmaceutica (Mar. 30, 2000) at 2.

<sup>345</sup> *Id.*

- 1           ○ Misrepresented “[s]ignificant improvement in social functioning.”
- 2           ○ Misrepresented outcome claims that were misleading because they
- 3           lacked substantial support, evidence or clinical experience and
- 4           “impl[ied] that patients will experience improved social or physical
- 5           functioning or improved work productivity when using Duragesic,”
- 6           including: “1,360 loaves . . . and counting, [w]ork, uninterrupted,
- 7           [life], uninterrupted, [g]ame, uninterrupted, [c]hronic pain relief that
- 8           supports functionality, [h]elps patients think less about their pain, and
- 9           [i]mprove[s] . . . physical and social functioning.”<sup>346</sup>
- 10          ○ Misrepresented that “[o]pioid analgesics, for example, have no true
- 11          ‘ceiling dose’ for analgesia and do not cause direct organ damage.”<sup>347</sup>

12           *Use of Opioid Analgesics in Pain Management*

13           Opioid analgesics are often the first line of treatment for many painful  
14           conditions and may offer advantages over nonsteroidal anti-inflammatory  
15           drugs (NSAIDs). Opioid analgesics, for example, have no true “**ceiling** dose”  
16           for analgesia and do not cause direct organ damage; however, they do have  
17           several possible side effects, including constipation, nausea, vomiting, a  
decrease in sexual interest, drowsiness, and respiratory depression. With the  
exception of constipation, many patients often develop tolerance to most of  
the opioid analgesic-related side effects.<sup>8</sup>

- 18          ○ **Myth:** Opioids make it harder to function normally.
- 19          **Fact:** When used correctly for appropriate conditions, opioids may  
20          make it easier for people to live normally.<sup>348</sup>
- 21          ○ Janssen sponsored a patient education guide titled *Finding Relief:*  
22           *Pain Management for Older Adults* (2009), which its personnel  
23           reviewed and approved and its sales force distributed. This guide

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<sup>346</sup> *Id.* at 3 (internal quotations omitted).

26           <sup>347</sup> *Use of Opioid Analgesics in Pain Management*, Prescribe Responsibly,  
27           <http://www.prescriberesponsibly.com/articles/opioid-pain-management> (last  
visited Dec. 11, 2017).

28           <sup>348</sup> *Finding Relief*, *Pain Management for Older Adults*, (2009) (emphasis in  
original).

1           features a man playing golf on the cover and lists examples of  
2           expected functional improvement from opioids, like sleeping through  
3           the night, returning to work, recreation, sex, walking, and climbing  
4           stairs. The guide states as a “fact” that “opioids may make it easier  
5           for people to live normally” (emphasis in the original). The myth/fact  
6           structure implies authoritative backing for the claim that does not  
7           exist. The targeting of older adults also ignored heightened opioid  
8           risks in this population.

- 9           ○ Janssen sponsored, developed, and approved content of a website,  
10           *Let's Talk Pain* in 2009, acting in conjunction with the APF and  
11           AAPM whose participation in Let's Talk Pain Janssen financed and  
12           orchestrated. This website featured an interview, which was edited by  
13           Janssen personnel, claiming that opioids were what allowed a patient  
14           to “continue to function,” inaccurately implying her experience  
15           would be representative. This video is still available today on  
16           youtube.com.
- 17           ○ Janssen provided grants to APF to distribute *Exit Wounds* to veterans,  
18           which taught that opioid medications “increase your level of  
19           functioning” (emphasis in the original). *Exit Wounds* also omits  
20           warnings of the risk of interactions between opioids and  
21           benzodiazepines, which would increase fatality risk. Benzodiazepines  
22           are frequently prescribed to veterans diagnosed with post-traumatic  
23           stress disorder.

24           • Cephalon:

- 25           ○ Cephalon sponsored the FSMB’s Responsible Opioid Prescribing  
26           (2007), which taught that relief of pain itself improved patients’  
27           function. Responsible Opioid Prescribing explicitly describes

1                   functional improvement as the goal of a “long-term therapeutic  
 2                   treatment course.” Cephalon also spent \$150,000 to purchase copies  
 3                   of the book in bulk and distributed the book through its pain sales  
 4                   force to 10,000 prescribers and 5,000 pharmacists.

- 5                   ○ Cephalon sponsored the American Pain Foundation’s *Treatment*  
 6                   *Options: A Guide for People Living with Pain* (2007), which taught  
 7                   patients that opioids when used properly “give [pain patients] a  
 8                   quality of life we deserve.” The *Treatment Options* guide notes that  
 9                   non-steroidal anti-inflammatory drugs have greater risks with  
 10                  prolonged duration of use, but there was no similar warning for  
 11                  opioids. APF distributed 17,200 copies in one year alone, according  
 12                  to its 2007 annual report, and the publication is currently available  
 13                  online.
- 14                  ○ Cephalon sponsored a CME written by Dr. Webster, titled  
 15                  Optimizing Opioid Treatment for Breakthrough Pain, which was  
 16                  offered online by Medscape, LLC from September 28, 2007, through  
 17                  December 15, 2008. The CME taught that Cephalon’s Actiq and  
 18                  Fentora improve patients’ quality of life and allow for more activities  
 19                  when taken in conjunction with long-acting opioids.

20                  ● Endo:

- 21                  ○ Opana ER “will benefit patients, physicians and payers.”<sup>349</sup>  
 22                  “Patient safety is our top concern and addressing appropriate use of opioids is a responsibility  
 23                  that we take very seriously. We firmly believe this new formulation of Opana ER, coupled with  
 24                  our long-term commitment to awareness and education around appropriate use of opioids will  
 25                  benefit patients, physicians and payers.”

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 27                  <sup>349</sup> *FDA Approves Endo Pharmaceuticals’ Crush-Resistant Opana ER*, December  
 28                  12, 2011, [https://www.biopharm.com/article/releases/fda-approves-endo-](https://www.biopharm.com/article/releases/fda-approves-endo-pharmaceuticals-crush-resistant-pana-er/)  
                       pharmaceuticals-crush-resistant-pana-er/-.

- 1           ○ “Endo distributed a pamphlet in New York and posted on its public  
2           website, www.opana.com, photographs of purported Opana ER  
3           patients that implied that patients can achieve higher function with  
4           Opana ER.”<sup>350</sup>
- 5           ○ Endo sponsored a website, painknowledge.com, through APF and  
6           NIPC, which claimed in 2009 that with opioids, “your level of  
7           function should improve; you may find you are now able to  
8           participate in activities of daily living, such as work and hobbies, that  
9           you were not able to enjoy when your pain was worse.” Endo  
10          continued to provide funding for this website through 2012, and  
11          closely tracked unique visitors to it.
- 12          ○ A CME sponsored by Endo, titled *Persistent Pain in the Older*  
13          *Patient*, taught that chronic opioid therapy has been “shown to reduce  
14          pain and improve depressive symptoms and cognitive functioning.”
- 15          ○ Endo distributed handouts to prescribers that claimed that use of  
16          Opana ER to treat chronic pain would allow patients to perform work  
17          as a chef. This flyer also emphasized Opana ER’s indication without  
18          including equally prominent disclosure of the “moderate to severe  
19          pain” qualification.
- 20          ○ Endo’s sales force distributed FSMB’s *Responsible Opioid*  
21          *Prescribing* (2007). This book taught that relief of pain itself  
22          improved patients’ function. Responsible Opioid Prescribing  
23          explicitly describes functional improvement as the goal of a “long-  
24          term therapeutic treatment course.”
- 25          ○ Endo provided grants to APF to distribute *Exit Wounds* to veterans,  
26          which taught that opioid medications “increase your level of

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28          <sup>350</sup> *Id.* at 8.

1 functioning” (emphasis in the original). Exit Wounds also omits  
 2 warnings of the risk of interactions between opioids and  
 3 benzodiazepines, which would increase fatality risk. Benzodiazepines  
 4 are frequently prescribed to veterans diagnosed with post-traumatic  
 5 stress disorder.

6 531. The RICO Marketing Defendants misrepresented that addiction risks  
 7 can be avoided or managed through screening tools and prescription guidelines:

- 8 • Purdue:
  - 9 ○ Purdue’s unbranded website, In the Face of Pain  
  10 (inthefaceofpain.com) states that policies that “restrict[] access to  
  11 patients with pain who also have a history of substance abuse” and  
  12 “requiring special government-issued prescription forms for the only  
  13 medications that are capable of relieving pain that is severe” are “at  
  14 odds with” best medical practices.<sup>351</sup>
  - 15 ○ Purdue sponsored a 2012 CME program taught by a KOL titled  
  16 *Chronic Pain Management and Opioid Use: Easing Fears,  
  17 Managing Risks, and Improving Outcomes*. This presentation  
  18 recommended that use of screening tools, more frequent refills, and  
  19 switching opioids could treat a high-risk patient showing signs of  
  20 potentially addictive behavior.
  - 21 ○ Purdue sponsored a 2011 webinar taught by Dr. Lynn Webster, titled  
  22 *Managing Patient’s Opioid Use: Balancing the Need and Risk*. This  
  23 publication taught prescribers that screening tools, urine tests, and  
  24

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 27 <sup>351</sup> See In the Face of Pain Fact Sheet: Protecting Access to Pain Treatment, Purdue  
 28 Pharma L.P. (Resources verified Mar. 2012),  
[www.inthefaceofpain.com/content/uploads/2011/12/factsheet\\_ProtectingAccess.pdf](http://www.inthefaceofpain.com/content/uploads/2011/12/factsheet_ProtectingAccess.pdf).

1                   patient agreements have the effect of preventing “overuse of  
2                   prescriptions” and “overdose deaths.”

- 3                   ○ Purdue sales representatives told prescribers that screening tools can  
4                   be used to select patients appropriate for opioid therapy and to  
5                   manage the risks of addiction.

6                   • Cephalon:

- 7                   ○ Cephalon sponsored APF’s *Treatment Options: A Guide for People*  
8                   *Living with Pain* (2007), which taught patients that “opioid  
9                   agreements” between doctors and patients can “ensure that you take  
10                  the opioid as prescribed.”

11                  • Endo:

- 12                  ○ Endo paid for a 2007 supplement<sup>352</sup> available for continuing  
13                  education credit in the Journal of Family Practice and written by a  
14                  doctor who later became a member of Endo’s speakers bureau. This  
15                  publication, titled *Pain Management Dilemmas in Primary Care: Use of Opioids*, recommended screening patients using tools like the  
16                  Opioid Risk Tool or the Screener and Opioid Assessment for Patients  
17                  with Pain, and advised that patients at high risk of addiction could  
18                  safely (e.g., without becoming addicted) receive chronic opioid  
19                  therapy using a “maximally structured approach” involving  
20                  toxicology screens and pill counts.

22                  532. The RICO Marketing Defendants misrepresented that signs of opioid  
23                  addiction were not addiction, withdrawal could be simply managed, and promoted  
24                  the concept of pseudoaddiction:

25                  • Purdue:

27                  

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28                  <sup>352</sup> The Medical Journal, *The Lancet* found that all of the supplement papers it received failed peer-review. Editorial, “*The Perils of Journal and Supplement Publishing*,” 375 *The Lancet* 9712 (347) 2010.

- 1           ○ Purdue published a prescriber and law enforcement education  
2           pamphlet in 2011 entitled *Providing Relief, Preventing Abuse*, which  
3           described pseudoaddiction as a concept that “emerged in the  
4           literature to describe the inaccurate interpretation of [drug-seeking  
5           behaviors] in patients who have pain that has not been effectively  
6           treated.”
- 7           ○ Purdue distributed to physicians, at least as of November 2006 and  
8           posted on its unbranded website, Partners Against Pain, a pamphlet  
9           copyrighted 2005 and titled *Clinical Issues in Opioid Prescribing*.  
10          This pamphlet included a list of conduct including “illicit drug use  
11          and deception” it defined as indicative of pseudoaddiction or  
12          untreated pain. It also states: “Pseudoaddiction is a term which has  
13          been used to describe patient behaviors that may occur when pain is  
14          undertreated. . . . Even such behaviors as illicit drug use and  
15          deception can occur in the patient’s efforts to obtain relief.  
16          Pseudoaddiction can be distinguished from true addiction in that the  
17          behaviors resolve when the pain is effectively treated.”
- 18          ○ Purdue sponsored FSMB’s *Responsible Opioid Prescribing* (2007),  
19          which taught that behaviors such as “requesting drugs by name,  
20          “demanding or manipulative behavior,” seeing more than one doctor  
21          to obtain opioids, and hoarding, are all signs of pseudoaddiction.  
22          Purdue also spent over \$100,000 to support distribution of the book.
- 23          ○ Purdue sponsored APF’s *A Policymaker’s Guide to Understanding*  
24          *Pain & Its Management*, which states: “Pseudo-addiction describes  
25          patient behaviors that may occur when pain is undertreated. . . .  
26          Pseudo-addiction can be distinguished from true addiction in that this  
27          behavior ceases when pain is effectively treated.”

- A *Policymaker’s Guide to Understanding Pain & Its Management* also taught that “Symptoms of physical dependence can often be ameliorated by gradually decreasing the dose of medication during discontinuation,” but did not disclose the significant hardships that often accompany cessation of use.
  - Purdue sales representatives told prescribers that the effects of withdrawal from opioid use can be successfully managed.
  - Purdue sales representatives told prescribers that the potential for withdrawal on Butrans was low due to Butrans’ low potency and its extended release mechanism.
  - Janssen:
    - Janssen’s website, Let’s Talk Pain, stated from 2009 through 2011 that “pseudoaddiction . . . refers to patient behaviors that may occur when pain is under-treated” and “[p]seudoaddiction is different from true addiction because such behaviors can be resolved with effective pain management.”
    - A Janssen PowerPoint presentation used for training its sales representatives titled “*Selling Nucynta ER*” indicates that the “low incidence of withdrawal symptoms” is a “core message” for its sales force. This message is repeated in numerous Janssen training materials between 2009 and 2011. The studies supporting this claim did not describe withdrawal symptoms in patients taking Nucynta ER beyond 90 days or at high doses and would therefore not be representative of withdrawal symptoms in the chronic pain population. Patients on opioid therapy long-term and at high doses will have a harder time discontinuing the drugs and are more likely to experience withdrawal symptoms. In addition, in claiming a low rate

of withdrawal symptoms, Janssen relied upon a study that only began tracking withdrawal symptoms in patients two to four days after discontinuing opioid use, when Janssen knew or should have known that these symptoms peak earlier than that for most patients. Relying on data after that initial window painted a misleading picture of the likelihood and severity of withdrawal associated with chronic opioid therapy. Janssen also knew or should have known that the patients involved in the study were not on the drug long enough to develop rates of withdrawal symptoms comparable to rates of withdrawal suffered by patients who use opioids for chronic pain—the use for which Janssen promoted Nucynta ER.

- Janssen sales representatives told prescribers that patients on Janssen's drugs were less susceptible to withdrawal than those on other opioids.

- Cephalon:

- Cephalon sponsored FSMB's Responsible Opioid Prescribing (2007), which taught that behaviors such as "requesting drugs by name," "demanding or manipulative behavior," seeing more than one doctor to obtain opioids, and hoarding are all signs of pseudoaddiction. Cephalon also spent \$150,000 to purchase copies of the book in bulk and distributed it through its pain sales force to 10,000 prescribers and 5,000 pharmacists.

- Endo:

- Endo distributed copies of a book by KOL Dr. Lynn Webster entitled *Avoiding Opioid Abuse While Managing Pain* (2007). Endo's internal planning documents describe the purpose of distributing this book as to "[i]ncrease the breadth and depth of the Opana ER prescriber

base.” The book claims that when faced with signs of aberrant behavior, the doctor should regard it as pseudoaddiction and thus, increasing the dose in most cases . . . should be the clinician’s first response.”

- Endo spent \$246,620 to buy copies of FSMB’s *Responsible Opioid Prescribing* (2007), which was distributed by Endo’s sales force. This book asserted that behaviors such as “requesting drugs by name,” “demanding or manipulative behavior,” seeing more than one doctor to obtain opioids, and hoarding, are all signs of “pseudoaddiction.”
- A CME sponsored by Endo, titled *Persistent Pain in the Older Adult*, taught that withdrawal symptoms can be avoided entirely by tapering the dose by 10-20% per day for ten days.
- Endo misrepresented that “symptoms of withdrawal do not indicate addiction.”<sup>353</sup>
- “Endo also trained its sales representatives to distinguish addiction from ‘pseudoaddiction.’”<sup>354</sup>

533. The RICO Defendants misrepresented that opioids were safe for the long-term treatment of chronic, non-acute, and non-cancer pain:

- Purdue:

- “[W]e do not want to niche OxyContin just for cancer pain.”<sup>355</sup>

three tablet strengths were passed around. OxyContin will be indicated for the relief of pain with the convenience of q12h dosing. OxyContin's primary market positioning will be for cancer pain and the secondary market will be for non-malignant pain (musculoskeletal, injury and trauma). It was reinforced that we do not want to niche OxyContin just for cancer pain. OxyContin will be positioned into Step 2 of the

<sup>353</sup> *In the Matter of Endo Health Solutions Inc. and Endo Pharmaceuticals Inc.*, Assurance No. 15-228, Assurance of Discontinuance Under Executive Law Section 63, Subdivision 15, at 7 (Mar. 1, 2016), [https://ag.ny.gov/pdfs/Endo\\_AOD\\_030116-Fully\\_Executed.pdf](https://ag.ny.gov/pdfs/Endo_AOD_030116-Fully_Executed.pdf).

<sup>354</sup> *Id.*

<sup>355</sup> Ryan, *Description of Hell*, <http://documents.latimes.com/oxycontin-launch-1995/> (emphasis in the L.A. Times document).

- 1           ○ OxyContin was safe and non-addictive when using extended release  
2           formulations, and appropriate for use in non-cancer patients.<sup>356</sup>
- 3           ○ OxyContin should be prescribed not merely for severe short-term  
4           pain associated with surgery or cancer, but also for less acute, longer-  
5           lasting pain like arthritis, back pain, sports injuries, fibromyalgia with  
6           almost limitless treatment potential.<sup>357</sup>

7           • Janssen:

- 8           ○ Duragesic was “more useful in a broader range of conditions or  
9           patients than has been demonstrated by substantial evidence.”<sup>358</sup>
- 10          ○ Duragesic was “not just for end stage cancer anymore” when the  
11           FDA only approved Duragesic for “the management of chronic pain  
12           in patients who require continuous opioid analgesia for pain that  
13           cannot be managed by lesser means.”<sup>359</sup>
- 14          ○ Misrepresented that “Duragesic can be used for any type of pain  
15           management” despite the fact that the FDA approved warning stated  
16           that     “BECAUSE     SERIOUS     OR     LIFE-THREATENING  
17           HYPOVENTILATION     COULD     OCCUR,     DURAGESIC®  
18           (FENTANYL           TRANSDERMAL           SYSTEM)     IS

22          <sup>356</sup> Charles Ornstein & Tracy Weber, *American Pain Foundation Shuts Down as*  
23          *Senators Launch Investigation of Prescription Narcotics*, ProPublica (May 8,  
24          2012, 8:57 PM),  
25          [http://www.opb.org/news/article/america\\_pain\\_foundation\\_shuts\\_down\\_as\\_senators\\_launch\\_investigation\\_of\\_prescription\\_narcotics/](http://www.opb.org/news/article/america_pain_foundation_shuts_down_as_senators_launch_investigation_of_prescription_narcotics/) (hereinafter “Ornstein,  
26          *American Pain Foundation*

27          <sup>357</sup> Patrick Keefe, *The Family that Built an Empire of Pain*, New Yorker (Oct. 30,  
28          2017), <https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain>

27          <sup>358</sup> NDA 19-813 Letter from Spencer Salis, U.S. Food & Drug Administration, to  
28          Cynthia Chianese, Janssen Pharmaceutica (Mar. 30, 2000) at 2.

28          <sup>359</sup> *Id.*

1                   CONTRAINDEDICATED: In the management of acute or post-  
 2                   operative pain, including use in outpatient surgeries . . . .”<sup>360</sup>

- 3                   ○ Misrepresented “numerous claims for the efficacy and safety of  
 4                   Duragesic,” but failed to “present[] any risk information concerning  
 5                   the boxed warnings, contraindications, warnings, or side effects  
 6                   associated with Duragesic’s use . . . [and] . . . fail[ed] to address  
 7                   important risks and restrictions associated with Duragesic  
 8                   therapy.”<sup>361</sup>
- 9                   ○ Misrepresented “[d]emonstrated effectiveness in chronic back pain  
 10                  with additional patient benefits, . . . 86% of patients experienced  
 11                  overall benefit in a clinical study based on: pain control, disability in  
 12                  ADLs, quality of sleep.”<sup>362</sup>

13                  ● Cephalon:

- 14                   ○ “[P]romoting [Actiq] for non-cancer patients to use for such maladies  
 15                  as migraines, sickle-cell pain crises, injuries, and in anticipation of  
 16                  changing wound dressings or radiation therapy.”<sup>363</sup>
- 17                   ○ “[P]romot[ing] Actiq for use in patients who were not yet opioid  
 18                  tolerant, and for whom it could have life-threatening results.”<sup>364</sup>
- 19                   ○ In 2011, Cephalon wrote an article titled “2011 Special Report: An  
 20                  Integrated Risk Evaluation and Risk Mitigation Strategy for Fentanyl  
 21                  Buccal Tablet (FENTORA®) AND Oral Transmucosal Fentanyl  
 22                  Citrate (Actiq®), published in Pain Medicine News. Plaintiffs are

24                  <sup>360</sup> *Id.*

25                  <sup>361</sup> *Id.*

26                  <sup>362</sup> *Id.* at 2-3.

27                  <sup>363</sup> Press Release, U.S. Department of Justice, Pharmaceutical Company Cephalon  
 28                  To Pay \$425 Million For Off-Label Drug Marketing (Sept. 29, 2008),  
<https://www.justice.gov/archive/usao/pae/News/2008/sep/cephalonrelease.pdf>.

<sup>364</sup> *Id.*

1                   informed and believe that Cephalon misrepresented that its drugs  
2                   were “shown to be effective in treatment of [break through pain]  
3                   associated with multiple causes of pain,” not just cancer.

4       534. The RICO Defendants also misrepresented that opioids were safer  
5                   than non-opioid analgesics because there is no ceiling dose for opioid treatment.

6                   • Purdue:

- 7                   ○ Purdue’s In the Face of Pain website, along with initiatives of APF,  
8                   promoted the notion that if a patient’s doctor does not prescribe them  
9                   what—in their view—is a sufficient dose of opioids, they should find  
10                  another doctor who will. In so doing, Purdue exerted undue, unfair,  
11                  and improper influence over prescribers who face pressure to accede  
12                  to the resulting demands.
- 13                  ○ Purdue sponsored APF’s *A Policymaker’s Guide to Understanding*  
14                  *Pain & Its Management*, which taught that dose escalations are  
15                  “sometimes necessary,” even indefinitely high ones, which suggested  
16                  that high dose opioids are safe and appropriate and did not disclose  
17                  the risks from high dose opioids. This publication is still available  
18                  online.
- 19                  ○ Purdue sponsored APF’s *Treatment Options: A Guide for People*  
20                  *Living with Pain* (2007), which taught patients that opioids have “no  
21                  ceiling dose” and are therefore the most appropriate treatment for  
22                  severe pain. The guide also claimed that some patients “need” a  
23                  larger dose of the drug, regardless of the dose currently prescribed.  
24                  This language fails to disclose heightened risks at elevated doses.
- 25                  ○ *Treatment Options*, also taught that opioids differ from NSAIDs in  
26                  that they have “no ceiling dose” and are therefore the most  
27                  appropriate treatment for severe pain. *Treatment Options* continued,
- 28

1 warning that risks of NSAIDs increase if “taken for more than a  
2 period of months,” with no corresponding warning about opioids.  
3 The publication attributed 10,000 to 20,000 deaths annually to  
4 NSAID overdose.

- 5 o Purdue sponsored a CME issued by the American Medical  
6 Association in 2003, 2007, 2010, and 2013. The CME, *Overview of*  
7 *Management Options*, was edited by KOL Dr. Russell Portenoy,  
8 among others, and taught that other drugs, but not opioids, are unsafe  
9 at high doses. The 2013 version is still available for CME credit.
- 10 o *Overview of Management Options* also taught NSAIDs and other  
11 drugs, but not opioids, are unsafe at high doses.
- 12 o Purdue sponsored APF’s *Exit Wounds* (2009), which omits warnings  
13 of the risk of interactions between opioids and benzodiazepines,  
14 which would increase fatality risk. *Exit Wounds* also contained a  
15 lengthy discussion of the dangers of using alcohol to treat chronic  
16 pain but did not disclose dangers of mixing
- 17 o Purdue sales representatives told prescribers that opioids were just as  
18 effective for treating patients long-term and omitted any discussion  
19 that increased tolerance would require increasing, and increasingly  
20 dangerous, doses.
- 21 o Purdue sales representatives told prescribers that NSAIDs were more  
22 toxic than opioids.

23 • Janssen:

- 24 o Janssen sponsored a patient education guide entitled *Finding Relief:*  
25 *Pain Management for Older Adults* (2009), which its personnel  
26 reviewed and approved and its sales force distributed. This guide  
27 listed dose limitations as “disadvantages” of other pain medicines but

omitted any discussion of risks of increased doses from opioids. The publication also falsely claimed that it is a “myth” that “opioid doses have to be bigger over time.”

- *Finding Relief: Pain Management for Older Adults* also described the advantages and disadvantages of NSAIDs on one page, and the “myths/facts” of opioids on the facing page. The disadvantages of NSAIDs are described as involving “stomach upset or bleeding,” “kidney or liver damage if taken at high doses or for a long time,” “adverse reactions in people with asthma,” and “can increase the risk of heart attack and stroke.” The only adverse effects of opioids listed are “upset stomach or sleepiness,” which the brochure claims will go away, and constipation.
- Janssen sponsored APF’s *Exit Wounds* (2009), which omits warnings of the risk of interactions between opioids and benzodiazepines. Janssen’s label for Duragesic, however, states that use with benzodiazepines “may cause respiratory depression, [low blood pressure], and profound sedation or potentially result in coma. Exit Wounds also contained a lengthy discussion of the dangers of using alcohol to treat chronic pain but did not disclose dangers of mixing alcohol and opioids.
- Janssen sales representatives told prescribers that Nucynta was not an opioid, making it a good choice for chronic pain patients who previously were unable to continue opioid therapy due to excessive side effects. This statement was misleading because Nucynta is an opioid and has the same effects as other opioids.

- Cephalon:

- Cephalon sponsored APF's *Treatment Options: A Guide for People Living with Pain* (2007), which claims that some patients "need" a larger dose of their opioid, regardless of the dose currently prescribed.
- *Treatment Options*, also taught patients that opioids differ from NSAIDs in that they have "no ceiling dose" and are therefore the most appropriate treatment for severe pain. *Treatment Options* continued, warning that risks of NSAIDs increase if "taken more than a period of months." With no corresponding warning about opioids. The publication attributed 10,000 to 20,000 deaths annually to NSAID overdose.
- Cephalon sponsored a CME written by KOL Dr. Lynn Webster, *Optimizing Opioid Treatment for Breakthrough Pain*, which was offered online by Medscape, LLC from September 28, 2007 through December 15, 2008. The CME taught that non-opioid analgesics and combination opioids that include aspirin and acetaminophen are less effective to treat breakthrough pain because of dose limitations.
- Cephalon sales representatives assured prescribers that opioids were safe, even at high doses.
- Cephalon sales representatives told prescribers that NSAIDs were more toxic than opioids.
- "[P]romot[ing] Actiq for use in patients who were not yet opioid tolerant, and for whom it could have life-threatening results."<sup>365</sup>

- Endo:

- Endo sponsored a website, painknowledge.com, through APF and NIPC, which claimed in 2009 that opioids may be increased until

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<sup>365</sup> *Id.*

- 1 “you are on the right dose of medication for your pain,” and once that  
2 occurs, further dose increases would not occur. Endo funded the site,  
3 which was a part of Endo’s marketing plan, and tracked visitors to it.  
4 ○ Through painknowledge.com Endo distributed a flyer called “Pain:  
5 Opioid Therapy.” This publication included a list of adverse effects  
6 from opioids that omitted significant adverse effects like  
7 hyperalgesia, immune and hormone dysfunction, cognitive  
8 impairment, tolerance, dependence, addiction, and death. Endo  
9 continued to provide funding for this website through 2012, and  
10 closely tracked unique visitors to it.  
11 ○ Endo provided grants to APF to distribute Exit Wounds (2009),  
12 which omitted warnings of the risk of interactions between opioids  
13 and benzodiazepines, which would increase fatality risk. Exit  
14 Wounds also contained a lengthy discussion of the dangers of using  
15 alcohol to treat chronic pain but did not disclose dangers of mixing  
16 alcohol and opioids.  
17 ○ Endo sales representatives told prescribers that NSAIDs were more  
18 toxic than opioids.  
19 ○ Endo distributed a patient education pamphlet edited by KOL Dr.  
20 Russell Portenoy titled *Understanding Your Pain: Taking Oral*  
21 *Opioid Analgesics*. In Q&A format, it asked: “If I take the opioid  
22 now, will it work later when I really need it?” The response was:  
23 “The dose can be increased . . . You won’t ‘run out’ of pain relief.”  
24 ○ Endo distributed a “case study” to prescribers titled *Case Challenges*  
25 *in Pain Management: Opioid Therapy for Chronic Pain*. The study  
26 cites an example, meant to be representative, of a patient “with a  
27 massive upper gastrointestinal bleed believed to be related to his  
28

1                   protracted use of NSAIDs” (over eight years), and recommends  
2                   treating with opioids instead.

3       535. These misrepresentations, and the legion of other representations  
4       made by the RICO Defendants and members of Opioid Marketing Enterprise all  
5       furthered the common purpose and fraudulent scheme of the Opioid Marketing  
6       Enterprise. But they were demonstrably false, as confirmed by investigations and  
7       enforcement actions against the RICO Marketing Defendants.

8       536. In May 2007, Purdue and three of its executives pled guilty to federal  
9       charges of misbranding OxyContin in what the company acknowledged was an  
10       attempt to mislead doctors about the risk of addiction. Purdue was ordered to pay  
11       \$600 million in fines and fees. In its plea, Purdue admitted that its promotion of  
12       OxyContin was misleading and inaccurate, misrepresented the risk of addiction  
13       and was unsupported by science. The Order adopting the guilty pleas provide:

14  
15                   effects than immediate-release opioids resulting in less  
16                   euphoria and less potential for abuse than short-acting  
17                   opioids;

- 18                   d. Told certain health care providers that patients could stop  
19                   therapy abruptly without experiencing withdrawal  
20                   symptoms and that patients who took OxyContin would not  
21                   develop tolerance to the drug; and  
22  
23                   e. Told certain health care providers that OxyContin did not  
24                   cause a “buzz” or euphoria, caused less euphoria, had less  
25                   addiction potential, had less abuse potential, was less likely  
26                   to be diverted than immediate-release opioids, and could be  
27                   used to “weed out” addicts and drug seekers.

28                   (Information ¶ 19.) Purdue has agreed that these facts are true, and the individual  
29                   defendants, while they do not agree that they had knowledge of these things, have  
30                   agreed that the court may accept these facts in support of their guilty pleas. (Agreed  
31                   Statement of Facts ¶ 46.)

32       537. Additionally, Michael Friedman (“Friedman”), the company’s  
33       president, pled guilty to a misbranding charge and agreed to pay \$19 million in

1 fines; Howard R. Udell (“Udell”), Purdue’s top lawyer, also pled guilty and  
 2 agreed to pay \$8 million in fines; and Paul D. Goldenheim (“Goldenheim”), its  
 3 former medical director, pled guilty as well and agreed to pay \$7.5 million in  
 4 fines.<sup>366</sup>

5       538. In a statement announcing the guilty plea, John Brownlee  
 6 (“Brownlee”), the U.S. Attorney for the Western District of Virginia, stated:

7           Purdue claimed it had created the miracle drug – a low risk drug that  
 8 could provide long acting pain relief but was less addictive and less  
 9 subject to abuse. Purdue’s marketing campaign worked, and sales for  
 OxyContin skyrocketed – making billions for Purdue and millions for  
 its top executives.

10          But OxyContin offered no miracles to those suffering in pain. Purdue’s claims that OxyContin was less addictive and less subject to abuse and diversion were false – and Purdue knew its claims were false. The result of their misrepresentations and crimes sparked one of our nation’s greatest prescription drug failures. . . . OxyContin was the child of marketers and bottom line financial decision making.<sup>367</sup>

11       539. Brownlee characterized Purdue’s criminal activity as follows:

12           First, Purdue trained its sales representatives to falsely inform  
 13 health care providers that it was more difficult to extract the  
 14 oxycodone from an OxyContin tablet for the purpose of intravenous  
 15 abuse. Purdue ordered this training even though its own study showed  
 16 that a drug abuser could extract approximately 68% of the oxycodone  
 17 from a single 10 mg OxyContin tablet by simply crushing the tablet,  
 18 stirring it in water, and drawing the solution through cotton into a  
 syringe.

19           Second, Purdue falsely instructed its sales representatives to  
 20 inform health care providers that OxyContin could create fewer  
 21 chances for addiction than immediate-release opioids.

22           Third, Purdue sponsored training that falsely taught Purdue  
 23 sales supervisors that OxyContin had fewer “peak and trough” blood  
 24 level effects than immediate-release opioids resulting in less euphoria  
 25 and less potential for abuse than short-acting opioids.

26           Fourth, Purdue falsely told certain health care providers that  
 27 patients could stop therapy abruptly without experiencing withdrawal

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28<sup>366</sup> *Id.*

<sup>367</sup> Press Release, U.S. Attorney for the Western District of Virginia, Statement of United States Attorney John Brownlee on the Guilty Plea of the Purdue Frederick Company and Its Executives for Illegally Misbranding OxyContin (May 10, 2007), <https://assets.documentcloud.org/documents/279028/purdue-guilty-plea.pdf>.

1 symptoms and that patients who took OxyContin would not develop  
 2 tolerance to the drug.

3 And fifth, Purdue falsely told health care providers that  
 4 OxyContin did not cause a “buzz” or euphoria, caused less euphoria,  
 5 had less addiction potential, had less abuse potential, was less likely to  
 6 be diverted than immediate-release opioids, and could be used to  
 7 “weed out” addicts and drug seekers.<sup>368</sup>

8 540. Purdue pled guilty to illegally misbranding OxyContin in an effort to  
 9 mislead and defraud physicians and consumers, while Friedman, Udell and  
 10 Goldenheim pled guilty to the misdemeanor charge of misbranding OxyContin for  
 11 introducing misbranded drugs into interstate commerce in violation of 21 U.S.C.  
 12 §§ 331(a), 333(a)(1)-(2) and 352(a).

13 541. Similarly, Endo’s marketing of Purdue was criticized and punished  
 14 by the FDA and New York Attorney General.

15 542. On February 18, 2017, the State of New York announced a  
 16 settlement with Endo requiring it “to cease all misrepresentations regarding the  
 17 properties of Opana ER [and] to describe accurately the risk of addiction to Opana  
 18 ER.”<sup>369</sup> In the Assurance of Discontinuance that effectuated the settlement, the  
 19 State of New York stated that Endo knew about the risks arising from the  
 20 reformulated Opana ER even before it received FDA approval. Among other  
 21 things, the investigation concluded that:

- 22 • Endo improperly marketed Opana ER as designed to be crush resistant,  
 23 when Endo’s own studies dating from 2009 and 2010 showed that the pill  
 24 could be crushed and ground;

25 \_\_\_\_\_  
 26 <sup>368</sup> *Id.*

27 <sup>369</sup> Press Release, Attorney General Eric T. Schneiderman, A.G. Schneiderman  
 28 Announces Settlement With Endo Health Solutions Inc. & Endo Pharmaceuticals  
 Inc. Over Marketing Of Prescription Opioid Drugs (Mar. 3, 2016),  
<https://ag.ny.gov/press-release/ag-schneiderman-announces-settlement-endo-health-solutions-inc-endo-pharmaceuticals> (last accessed on March 9, 2018).

- 1     • Endo improperly instructed its sales representatives to diminish and distort
- 2         the risks associated with Opana ER, including the serious danger of
- 3         addiction; and
- 4     • Endo made unsupported claims comparing Opana ER to other opioids and
- 5         failed to disclose accurate information regarding studies addressing the
- 6         negative effects of Opana ER.<sup>370</sup>

7                 543. The 2017 settlement also identified and discussed a February 2013  
 8 communication from a consultant hired by Endo to the company, in which the  
 9 consultant concluded that “[t]he initial data presented do not necessarily establish  
 10 that the reformulated Opana ER is tamper resistant.” The same consultant also  
 11 reported that the distribution of the reformulated Opana ER had already led to  
 12 higher levels of abuse of the drug via injection.<sup>371</sup>

13                 544. The Office of the Attorney General of New York also revealed that  
 14 the “managed care dossier” Endo provided to formulary committees of healthcare  
 15 plans and pharmacy benefit managers misrepresented the studies that had been  
 16 conducted on Opana ER. According to Endo’s vice president for  
 17 pharmacovigilance and risk management, the dossier was presented as a complete  
 18 compendium of all research on the drug. However, it omitted certain studies:  
 19 Study 108 (completed in 2009) and Study 109 (completed in 2010), which showed  
 20 that reformulated Opana ER could be ground and chewed.

21                 545. The settlement also detailed Endo’s false and misleading  
 22 representations about the non-addictiveness of opioids and Opana. For example,  
 23 until April 2012, Endo’s website for the drug, [www.opana.com](http://www.opana.com), contained the  
 24 following representation: “Most healthcare providers who treat patients with pain  
 25 agree that patients treated with prolonged opioid medicines usually do not become

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<sup>370</sup> *Id.*  
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<sup>371</sup> *Id.* at 6.

1 addicted.”<sup>372</sup> However, Endo neither conducted nor possessed a survey  
2 demonstrating that most healthcare providers who treat patients with pain agree  
3 with that representation.

4 546. The Office of the Attorney General of New York also disclosed the  
5 following facts that it determined to violate Opana’s obligations to truthfully  
6 market its products:

7 a. Training materials provided by Endo to sales  
8 representatives stated: “‘Symptoms of withdrawal do not  
9 indicate addiction.’”<sup>373</sup> This representation is inconsistent with  
10 the diagnosis of opioid-use disorder as provided in the  
11 Diagnostic and Statistical Manual of Mental Disorders by the  
12 American Psychiatric Association (Fifth Edition).

13 b. Endo trained its sales representatives to falsely  
14 distinguish addiction from “pseudoaddiction,” which it defined  
15 as a condition in which patients exhibit drug-seeking behavior  
16 that resembles but is not the same as addiction. Endo’s vice  
17 president for pharmacovigilance and risk management testified  
18 that he was not aware of any research validating the concept of  
19 pseudoaddiction.

20 547. On June 9, 2017, the FDA asked Endo to voluntarily cease sales of  
21 Opana ER after determining that the risks associated with its abuse outweighed  
22 the benefits. According to Dr. Janet Woodcock, director of the FDA’s Center for  
23 Drug Evaluation and Research, the risks include “several serious problems,”  
24 including “outbreaks of HIV and Hepatitis C from sharing the drug after it was

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<sup>372</sup> *Id.*

<sup>373</sup> *Id.* at 7.

1 extracted by abusers” and ““a serious disease outbreak.”<sup>374</sup> If Endo did not  
 2 comply, the FDA stated that it “intends to take steps to formally require its  
 3 removal by withdrawing approval.”<sup>375</sup>

4       548. Like Purdue and Endo, Janssen was the subject of an FDA  
 5 enforcement action that identified its marketing statements as misrepresentations.  
 6 For example:

7       549. On February 15, 2000, the FDA sent Janssen a letter concerning the  
 8 alleged dissemination of “homemade” promotional pieces that promoted  
 9 Duragesic in violation of the Federal Food, Drug, and Cosmetic Act. In a  
 10 subsequent letter, dated March 30, 2000, the FDA explained that the “homemade”  
 11 promotional pieces were “false or misleading because they contain  
 12 misrepresentations of safety information, broaden Duragesic’s indication, contain  
 13 unsubstantiated claims, and lack fair balance.”<sup>376</sup>

14       550. The March 30, 2000 letter identified specific violations, including  
 15 misrepresentations that Duragesic had a low potential for abuse:

16       You present the claim, “Low abuse potential!” This claim suggests  
 17 that Duragesic has less potential for abuse than other currently  
 18 available opioids. However, this claim has not been demonstrated by  
 19 substantial evidence. Furthermore, this claim is contradictory to  
 20 information in the approved product labeling (PI) that states,  
 21 “Fentanyl is a Schedule II controlled substance and can produce drug  
 22 dependence similar to that produced by morphine.” Therefore, this  
 23 claim is false or misleading.<sup>377</sup>

24       551. The March 30, 2000 letter also stated that the promotional materials  
 25 represented that Duragesic was “more useful in a broader range of conditions or  
 26  
 27  
 28

<sup>374</sup> *FDA requests removal of Opana ER for risks related to abuse*, June 8, 2017,  
<https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm562401.htm>.

<sup>375</sup> *Id.*

<sup>376</sup> NDA 19-813 Letter from Spencer Salis, U.S. Food & Drug Administration, to  
 Cynthia Chianese, Janssen Pharmaceutica (Mar. 30, 2000) at 2.

<sup>377</sup> *Id.*

1 patients than has been demonstrated by substantial evidence.”<sup>378</sup> Specifically, the  
2 FDA stated that Janssen was marketing Duragesic for indications other than the  
3 treatment of chronic pain that cannot otherwise be managed, for which it was  
4 approved:

5 You present the claim, “It’s not just for end stage cancer anymore!”  
6 This claim suggests that Duragesic can be used for any type of pain  
7 management. However, the PI for Duragesic states, “Duragesic  
8 (fentanyl transdermal system) is indicated in the management of  
9 chronic pain in patients who require continuous opioid analgesia for  
10 pain that cannot be managed by lesser means . . .” Therefore, the  
11 suggestion that Duragesic can be used for any type of pain  
12 management promotes Duragesic[] for a much broader use than is  
13 recommended in the PI, and thus, is misleading. In addition, the  
14 suggestion that Duragesic can be used to treat any kind of pain is  
15 contradictory to the boxed warning in the PI. Specifically, the PI  
16 states,

17 BECAUSE SERIOUS OR LIFE-THREATENING  
18 HYPOVENTILATION COULD OCCUR, DURAGESIC®  
19 (FENTANYL TRANSDERMAL SYSTEM) IS  
20 CONTRAINDICATED:

21 In the management of acute or post-operative pain, including use in  
22 outpatient surgeries . . .<sup>379</sup>

23 552. The March 30, 2000 letter also stated Janssen failed to adequately  
24 present “contraindications, warnings, precautions, and side effects with a  
25 prominence and readability reasonably comparable to the presentation of  
26 information relating to the effectiveness of the product.”<sup>380</sup>

27 553. On February 15, 2000, the FDA sent Janssen a letter concerning the  
28 alleged dissemination of “homemade” promotional pieces that promoted  
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subsequent letter, dated March 30, 2000, the FDA explained that the “homemade”  
promotional pieces were “false or misleading because they contain

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27 <sup>378</sup> *Id.*

28 <sup>379</sup> *Id.* at 2-3.

<sup>380</sup> *Id.* at 3 (emphasis in original).

1 misrepresentations of safety information, broaden Duragesic's indication, contain  
2 unsubstantiated claims, and lack fair balance.”<sup>381</sup>

3 554. The March 30, 2000 letter identified specific violations, including  
4 misrepresentations that Duragesic had a low potential for abuse:

5 You present the claim, “Low abuse potential!” This claim suggests  
6 that Duragesic has less potential for abuse than other currently  
7 available opioids. However, this claim has not been demonstrated by  
8 substantial evidence. Furthermore, this claim is contradictory to  
9 information in the approved product labeling (PI) that states,  
“Fentanyl is a Schedule II controlled substance and can produce drug  
dependence similar to that produced by morphine.” Therefore, this  
claim is false or misleading.<sup>382</sup>

10 555. The March 30, 2000 letter also stated that the promotional materials  
11 represented that Duragesic was “more useful in a broader range of conditions or  
12 patients than has been demonstrated by substantial evidence.”<sup>383</sup> Specifically, the  
13 FDA stated that Janssen was marketing Duragesic for indications other than the  
14 treatment of chronic pain that cannot otherwise be managed, for which it was  
15 approved:

16 You present the claim, “It’s not just for end stage cancer anymore!”  
17 This claim suggests that Duragesic can be used for any type of pain  
18 management. However, the PI for Duragesic states, “Duragesic  
19 (fentanyl transdermal system) is indicated in the management of  
20 chronic pain in patients who require continuous opioid analgesia for  
21 pain that cannot be managed by lesser means . . .” Therefore, the  
22 suggestion that Duragesic can be used for any type of pain  
23 management promotes Duragesic[] for a much broader use than is  
24 recommended in the PI, and thus, is misleading. In addition, the  
25 suggestion that Duragesic can be used to treat any kind of pain is  
26 contradictory to the boxed warning in the PI. Specifically, the PI  
states,

27 BECAUSE SERIOUS OR LIFE-THREATENING  
28 HYPOVENTILATION COULD OCCUR, DURAGESIC®  
(FENTANYL TRANSDERMAL SYSTEM) IS  
CONTRAINdICATED:

26  
27 <sup>381</sup> NDA 19-813 Letter from Spencer Salis, U.S. Food & Drug Administration, to  
Cynthia Chianese, Janssen Pharmaceutica (Mar. 30, 2000) at 2.

28 <sup>382</sup> *Id.*

<sup>383</sup> *Id.*

1           In the management of acute or post-operative pain, including use in  
2           outpatient surgeries . . .<sup>384</sup>

3           556. The March 30, 2000 letter also stated Janssen failed to adequately  
4           present “contraindications, warnings, precautions, and side effects with a  
5           prominence and readability reasonably comparable to the presentation of  
6           information relating to the effectiveness of the product”:

7           Although this piece contains numerous claims for the efficacy and  
8           safety of Duragesic, you have not presented any risk information  
9           concerning the boxed warnings, contraindications, warnings,  
10          precautions, or side effects associated with Duragesic’s use . . .  
11          Therefore, this promotional piece is lacking in fair balance, or  
12          otherwise misleading, because it fails to address important risks and  
13          restrictions associated with Duragesic therapy.<sup>385</sup>

14          557. On September 2, 2004, the U.S. Department of Health and Human  
15          Services (“HHS”) sent Janssen a warning letter concerning Duragesic due to  
16          “false or misleading claims about the abuse potential and other risks of the drug,  
17          and . . . unsubstantiated effectiveness claims for Duragesic,” including,  
18          specifically, “suggesting that Duragesic has a lower potential for abuse compared  
19          to other opioid products.”

20          558. The September 2, 2004 letter warned Janssen regarding its claims  
21          that Duragesic had a low reported rate of mentions in the Drug Abuse Warning  
22          Network (“DAWN”) as compared to other opioids. The letter stated that the claim  
23          was false or misleading because the claim was not based on substantial data and  
24          because the lower rate of mentions was likely attributable to Duragesic’s lower  
25          frequency of use compared to other opioids listed in DAWN:

26           The file card presents the prominent claim, “Low reported rate  
27          of mentions in DAWN data,” along with Drug Abuse Warning  
28          Network (DAWN) data comparing the number of mentions for  
29          Fentanyl/combinations (710 mentions) to other listed opioid products,  
30          including Hydrocodone/combinations (21,567 mentions),  
31          Oxycodone/combinations (18,409 mentions), and Methadone (10,725  
32          mentions). The file card thus suggests that Duragesic is less abused  
33          than other opioid drugs.

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384 *Id.* at 2-3.

385 *Id.* at 3 (emphasis in original).

1           This is false or misleading for two reasons. First, we are not  
 2 aware of substantial evidence or substantial clinical experience to  
 3 support this comparative claim. The DAWN data cannot provide the  
 4 basis for a valid comparison among these products. As you know,  
 5 DAWN is not a clinical trial database. Instead, it is a national public  
 6 health surveillance system that monitors drug-related emergency  
 7 department visits and deaths. If you have other data demonstrating  
 8 that Duragesic is less abused, please submit them.

9           Second, Duragesic is not as widely prescribed as other opioid  
 10 products. As a result, the relatively lower number of mentions could  
 11 be attributed to the lower frequency of use, and not to a lower  
 12 incidence of abuse. The file card fails to disclose this information.<sup>386</sup>

13           559. The September 2, 2004 letter also detailed a series of unsubstantiated  
 14 false or misleading claims regarding Duragesic's effectiveness. The letter  
 15 concluded that various claims made by Janssen were insufficiently supported,  
 16 including:

- 17           • “Demonstrated effectiveness in chronic back pain with additional patient  
 18           benefits, . . . 86% of patients experienced overall benefit in a clinical study  
 19           based on: pain control, disability in ADLs, quality of sleep.””
- 20           • “All patients who experienced overall benefit from DURAGESIC would  
 21           recommend it to others with chronic low back pain.””
- 22           • “Significantly reduced nighttime awakenings.””
- 23           • “Significant improvement in disability scores as measured by the Oswestry  
 24           Disability Questionnaire and Pain Disability Index.””
- 25           • “Significant improvement in physical functioning summary score.””
- 26           • “Significant improvement in social functioning.””<sup>387</sup>

27           560. In addition, the September 2, 2004 letter identified “outcome claims  
 28 [that] are misleading because they imply that patients will experience improved  
 29 social or physical functioning or improved work productivity when using

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26           <sup>386</sup> Warning Letter from Thomas W. Abrams, U.S. Department of Health and  
 27 Human Services, to Ajit Shetty, Janssen Pharmaceutica, Inc. (Sept. 2, 2004),  
 28 [https://www.pharmamedtechbi.com/~media/Images/Publications/Archive/The%20Pink%20Sheet/66/038/00660380018/040920\\_duragesic\\_letter.pdf](https://www.pharmamedtechbi.com/~media/Images/Publications/Archive/The%20Pink%20Sheet/66/038/00660380018/040920_duragesic_letter.pdf) at 2.

387 *Id.* at 2-3.

1 Duragesic.” The claims include ““1,360 loaves . . . and counting,’ ‘[w]ork,  
 2 uninterrupted,’ ‘[l]ife, uninterrupted,’ ‘[g]ame, uninterrupted,’ ‘[c]hronic pain  
 3 relief that supports functionality,’ ‘[h]elps patients think less about their pain,’ and  
 4 ‘[i]mprove[s] . . . physical and social functioning.’” The September 2, 2004 letter  
 5 stated: “Janssen has not provided references to support these outcome claims. We  
 6 are not aware of substantial evidence or substantial clinical experience to support  
 7 these claims.”<sup>388</sup>

8       561. On July 15, 2005, the FDA issued a public health advisory warning  
 9 doctors of deaths resulting from the use of Duragesic and its generic competitor,  
 10 manufactured by Mylan N.V. Plaintiffs are informed and believe that the advisory  
 11 noted that the FDA had been ““examining the circumstances of product use to  
 12 determine if the reported adverse events may be related to inappropriate use of the  
 13 patch”” and noted the possibility “that patients and physicians might be unaware  
 14 of the risks” of using the fentanyl transdermal patch, which is a potent opioid  
 15 analgesic meant to treat chronic pain that does not respond to other painkillers.<sup>389</sup>

16       562. Finally, Cephalon has been the subject of investigations and  
 17 enforcement actions for its misrepresentations concerning Actiq. For example:

18       563. In October 2000, Cephalon acquired the worldwide product rights to  
 19 Actiq and began marketing and selling Actiq in the United States. The FDA  
 20 explicitly stated that Actiq “**must not** be used in opioid non-tolerant patients,” was  
 21 contraindicated for the management of acute or postoperative pain, could be  
 22 deadly to children, and was “intended to be used only in the care of opioid-  
 23 tolerant cancer patients and only by oncologists and pain specialists who are  
 24 knowledgeable of and skilled in the use of Schedule II opioids to treat cancer

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 28       <sup>388</sup> *Id.* at 3.

<sup>389</sup> *New Fentanyl Warnings: More Needed to Protect Patients*, Institute for Safe  
 Medication Practices, August 11, 2005,  
<https://www.ismp.org/newsletters/acutecare/articles/20050811.asp>

1 pain.”<sup>390</sup> The FDA also required that Actiq be provided only in compliance with a  
 2 strict risk management program that explicitly limited the drug’s direct marketing  
 3 to the approved target audiences, defined as oncologists, pain specialists, their  
 4 nurses and office staff.<sup>391</sup>

5       564. Cephalon purchased the rights to Fentora, an even faster-acting tablet  
 6 formulation of fentanyl, from Cima Labs, and submitted a new drug application to  
 7 the FDA in August 2005. In September 2006, Cephalon received FDA approval to  
 8 sell this faster-acting version of Actiq; but once again, concerned about the power  
 9 and risks inherent to fentanyl, the FDA limited Fentora’s approval to the treatment  
 10 of BTP in cancer patients who were already tolerant to around-the-clock opioid  
 11 therapy for their underlying persistent cancer pain. Cephalon began marketing and  
 12 selling Fentora in October 2006.

13       565. Due to the FDA’s restrictions, Actiq’s consumer base was limited, as  
 14 was its potential for growing revenue. In order to increase its revenue and market  
 15 share, Cephalon needed to find a broader audience and thus began marketing its  
 16 lollipop to treat headaches, back pain, sports injuries and other chronic non-cancer  
 17 pain, targeting non-oncology practices, including, but not limited to, pain doctors,  
 18 general practitioners, migraine clinics, anesthesiologists and sports clinics. It did  
 19 so in violation of applicable regulations prohibiting the marketing of medications  
 20 for off-label use and indirect contravention of the FDA’s strict instructions that  
 21 Actiq be prescribed only to terminal cancer patients and by oncologists and pain  
 22 management doctors experienced in treating cancer pain.

23       566. Beginning in or about 2003, former Cephalon employees filed four  
 24 whistleblower lawsuits claiming the company had wrongfully marketed Actiq for  
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27       <sup>390</sup> *Id.*  
 28       <sup>391</sup> See John Carreyrou, *Narcotic “Lollipop” Becomes Big Seller Despite FDA Curbs*, Wall St. J. (Nov. 3, 2006), <https://www.opiates.com/media/narcotic-lollipop-becomes-big-seller-despite-fdacurbs/>.

1 unapproved off-label uses. On September 29, 2008, Cephalon finalized and  
2 entered into a corporate integrity agreement with the Office of the Inspector  
3 General of HHS and agreed to pay \$425 million in civil and criminal penalties for  
4 its off-label marketing of Actiq and two other drugs (Gabitril and Provigil).

5 According to a DOJ press release, Cephalon trained sales representatives to  
6 disregard restrictions of the FDA-approved label, employed sales representatives  
7 and healthcare professionals to speak to physicians about off-label uses of the  
8 three drugs and funded CME to promote off-label uses. Specifically, the DOJ  
9 stated:

10 From 2001 through at least 2006, Cephalon was allegedly promoting  
11 [Actiq] for non-cancer patients to use for such maladies as migraines,  
12 sickle-cell pain crises, injuries, and in anticipation of changing wound  
13 dressings or radiation therapy. Cephalon also promoted Actiq for use  
14 in patients who were not yet opioid-tolerant, and for whom it could  
15 have life-threatening results.<sup>392</sup>

16 567. Then-acting U.S. Attorney Laurie Magid commented on the dangers  
17 of Cephalon's unlawful practices:

18 “This company subverted the very process put in place to protect the public  
19 from harm, and put patients' health at risk for nothing more than boosting  
20 its bottom line. People have an absolute right to their doctors' best medical  
21 judgment. They need to know the recommendations a doctor makes are not  
22 influenced by sales tactics designed to convince the doctor that the drug  
23 being prescribed is safe for uses beyond what the FDA has approved.”<sup>393</sup>

24 568. Upon information and belief, documents uncovered in the  
25 government's investigations confirm that Cephalon directly targeted non-  
26 oncology practices and pushed its sales representatives to market Actiq for off-  
27 label use. For instance, the government's investigations confirmed:  
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29 <sup>392</sup> Press Release, U.S. Department of Justice, Pharmaceutical Company Cephalon  
30 To Pay \$425 Million For Off-Label Drug Marketing (Sept. 29, 2008),  
31 <https://www.justice.gov/archive/usao/pae/News/2008/sep/cephalonrelease.pdf>.

32 <sup>393</sup> *Id.*

- 1           a. Cephalon instructed its sales representatives to ask non-cancer doctors  
2           whether they have the potential to treat cancer pain. Even if the doctor  
3           answered “no,” a decision tree provided by Cephalon instructed the sales  
4           representatives to give these physicians free Actiq coupons;
- 5           b. Cephalon targeted neurologists in order to encourage them to prescribe  
6           Actiq to patients with migraine headaches;
- 7           c. Cephalon sales representatives utilized the assistance of outside pain  
8           management specialists when visiting non-cancer physicians to pitch Actiq. The  
9           pain management specialist would falsely inform the physician that Actiq does not  
10          cause patients to experience a “high” and carries a low risk of diversion toward  
11          recreational use;
- 12          d. Cephalon set sales quotas for its sales and marketing representatives that  
13          could not possibly have been met solely by promoting Actiq for its FDA-approved  
14          indication;
- 15          e. Cephalon promoted the use of higher doses of Actiq than patients required  
16          by encouraging prescriptions of the drug to include larger-than-necessary numbers  
17          of lozenges with unnecessarily high doses of fentanyl; and
- 18          f. Cephalon promoted Actiq for off-label use by funding and controlling  
19           CME seminars that promoted and misrepresented the efficacy of the  
20           drug for off-label uses such as treating migraine headaches and for  
21           patients not already opioid-tolerant.<sup>394</sup>

22           569. The FDA’s letters and safety alerts, the DOJ and state investigations,  
23          and the massive settlement seemed to have had little impact on Cephalon as it  
24          continued its deceptive marketing strategy for both Actiq and Fentora.

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<sup>394</sup> John Carreyrou, Cephalon Used Improper Tactics to Sell Drug, Probe Finds,  
28          Wall St. J., Nov. 21, 2006, at B1 (hereinafter “Carreyrou, Cephalon Used Improper  
         Tactics”).

1       570. On September 27, 2007, the FDA issued a public health advisory to  
 2 address numerous reports that patients who did not have cancer or were not  
 3 opioid-tolerant had been prescribed Fentora, and death or life-threatening side  
 4 effects had resulted. The FDA warned: “Fentora should not be used to treat any  
 5 type of short-term pain.”<sup>395</sup>

6       571. Nevertheless, in 2008, Cephalon pushed forward to expand the target  
 7 base for Fentora and filed a supplemental drug application requesting FDA  
 8 approval of Fentora for the treatment of non-cancer BTP. In the application and  
 9 supporting presentations to the FDA, Cephalon admitted both that it knew the  
 10 drug was heavily prescribed for off-label use and that the drug’s safety for such  
 11 use had never been clinically evaluated.<sup>396</sup> An FDA advisory committee noted that  
 12 Fentora’s existing risk management program was ineffective and stated that  
 13 Cephalon would have to institute a risk evaluation and mitigation strategy for the  
 14 drug before the FDA would consider broader label indications. In response,  
 15 Cephalon revised Fentora’s label and medication guide to add strengthened  
 16 warnings.

17       572. But in 2009, the FDA once again informed Cephalon that the risk  
 18 management program was not sufficient to ensure the safe use of Fentora for  
 19 already approved indications.

20       573. On March 26, 2009, the FDA warned Cephalon against its  
 21 misleading advertising of Fentora (“Warning Letter”). The Warning Letter  
 22

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23       395 Press Release, U.S. Food & Drug Administration, Public Health Advisory:  
 24 Important Information for the Safe Use of Fentora (fentanyl buccal tablets) (Sept.  
 25 26, 2007), <https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm051273.htm>.

26       396 FENTORA (fentanyl buccal tablet) CII, Joint Meeting of Anesthetic and Life  
 27 Support Drugs and  
 28 Drug Safety and Risk Management Advisory Committee, U.S. Food & Drug  
 Administration (May 6, 2008), <https://www.fda.gov/ohrms/dockets/ac/08/slides/2008-4356s2-03-Cephalon.pdf>.

1 described a Fentora Internet advertisement as misleading because it purported to  
 2 broaden “the indication for Fentora by implying that any patient with cancer who  
 3 requires treatment for breakthrough pain is a candidate for Fentora . . . when this  
 4 is not the case.”<sup>397</sup> Rather, Fentora was only indicated for those who were already  
 5 opioid tolerant. It further criticized Cephalon’s other direct Fentora advertisements  
 6 because they did not disclose the risks associated with the drug.

7       574. Flagrantly disregarding the FDA’s refusal to approve Fentora for  
 8 non-cancer BTP and its warning against marketing the drug for the same,  
 9 Cephalon continued to use the same sales tactics to push Fentora as it did with  
 10 Actiq.

11       575. The misrepresentations disseminated by members of the Opioid  
 12 Marketing Enterprise, and the RICO Marketing Defendants, caused The County  
 13 and California consumers to pay for excessive opioid prescriptions, suffer injuries  
 14 and losses, and to incur costs associated with the opioid epidemic caused by the  
 15 Opioid Marketing Enterprise.

16       576. The RICO Marketing Defendants alone could not have accomplished  
 17 the purpose of the Opioid Marketing Enterprise without the assistance of the Front  
 18 Groups and KOLs, who were perceived as “neutral” and more “scientific” than  
 19 the RICO Defendants themselves. Without these misrepresentations, the Opioid  
 20 Marketing Enterprise could not have achieved its common purpose.

21       577. The impact of the Opioid Marketing Enterprise’s scheme is still in  
 22 place – i.e., the opioids continue to be prescribed and used for chronic pain  
 23 throughout the State of California, and the epidemic continues to injure The  
 24 County, and consume the resources of The County’s and California’s health care  
 25 and law enforcement systems.

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 27       <sup>397</sup> Letter from Michael Sauers, Regulatory Review Officer, Division of Drug  
 28 Marketing, Advertising and Communications, to Carole S. Marchione, Senior  
 Director and Group Leader, Regulatory Affairs (March 26, 2009)

1       578. The foregoing evidences that the RICO Marketing Defendants, the  
2 Front Groups, and the KOLs were each willing participants in the Opioid  
3 Marketing Enterprise, had a common purpose and interest in the object of the  
4 scheme, and functioned within a structure designed to effectuate the Enterprise's  
5 purpose.

6           **B. CONDUCT OF THE OPIOID MARKETING ENTERPRISE.**

7       579. During time period described in this Complaint, from approximately  
8 the late 1990s to the present, the RICO Marketing Defendants exerted control over  
9 the Opioid Marketing Enterprise and participated in the operation or management  
10 of the affairs of the Opioid Marketing Enterprise, directly or indirectly, in the  
11 following ways:

- 12           a. Creating a body of deceptive, misleading and unsupported medical and  
13           popular literature about opioids that (a) understated the risks and  
14           overstated the benefits of long-term use; (b) appeared to be the result of  
15           independent, objective research; and (c) was thus more likely to be  
16           relied upon by physicians, patients, and payors;
- 17           b. Creating a body of deceptive, misleading and unsupported electronic and  
18           print advertisements about opioids that (a) understated the risks and  
19           overstated the benefits of long-term use; (b) appeared to be the result of  
20           independent, objective research; and (c) was thus more likely to be  
21           relied upon by physicians, patients, and payors;
- 22           c. Creating a body of deceptive, misleading and unsupported sales and  
23           promotional training materials about opioids that (a) understated the  
24           risks and overstated the benefits of long-term use; (b) appeared to be the  
25           result of independent, objective research; and (c) was thus more likely to  
26           be relied upon by physicians, patients, and payors;
- 27           d. Creating a body of deceptive, misleading and unsupported CMEs and  
28           speaker presentations about opioids that (a) understated the risks and

overstated the benefits of long-term use; (b) appeared to be the result of independent, objective research; and (c) was thus more likely to be relied upon by physicians, patients, and payors;

- e. Selecting, cultivating, promoting and paying KOLs based solely on their willingness to communicate and distribute the RICO Defendants' messages about the use of opioids for chronic pain;
  - f. Providing substantial opportunities for KOLs to participate in research studies on topics the RICO Defendants suggested or chose, with the predictable effect of ensuring that many favorable studies appeared in the academic literature;
  - g. Paying KOLs to serve as consultants or on the RICO Defendants' advisory boards, on the advisory boards and in leadership positions on Front Groups, and to give talks or present CMEs, typically over meals or at conferences;
  - h. Selecting, cultivating, promoting, creating and paying Front Groups based solely on their willingness to communicate and distribute the RICO Defendants' messages about the use of opioids for chronic pain;
  - i. Providing substantial opportunities for Front Groups to participate in and/or publish research studies on topics the RICO Defendants suggested or chose (and paid for), with the predictable effect of ensuring that many favorable studies appeared in the academic literature;
  - j. Paying significant amounts of money to the leaders and individuals associated with Front Groups;
  - k. Donating to Front Groups to support talks or CMEs, that were typically presented over meals or at conferences;

1. Disseminating many of their false, misleading, imbalanced, and unsupported statements through unbranded materials that appeared to be independent publications from Front Groups;
  - m. Sponsoring CME programs put on by Front Groups that focused exclusively on the use of opioids for chronic pain;
  - n. Developing and disseminating pro-opioid treatment guidelines with the help of the KOLs as authors and promoters, and the help of the Front Groups as publishers, and supporters;
  - o. Encouraging Front Groups to disseminate their pro-opioid messages to groups targeted by the RICO Defendants, such as veterans and the elderly, and then funded that distribution;
  - p. Concealing their relationship to and control of Front Groups and KOLs from the The County and the public at large; and
  - q. Intending that Front Groups and KOLs would distribute through the U.S. mail and interstate wire facilities, promotional and other materials that claimed opioids could be safely used for chronic pain.

580. The Front Groups also participated in the conduct of the Opioid Marketing Enterprise, directly or indirectly, in the following ways:

- a. The Front Groups promised to, and did, make representations regarding opioids and the RICO Marketing Defendants' drugs that were consistent with the RICO Marketing Defendants' messages;
  - b. The Front Groups distributed, through the U.S. Mail and interstate wire facilities, promotional and other materials which claimed that opioids could be safely used for chronic pain without addiction, and misrepresented the benefits of using opioids for chronic pain outweighed the risks;

- 1                   c. The Front Groups echoed and amplified messages favorable to increased
- 2                   opioid use—and ultimately, the financial interests of the RICO
- 3                   Marketing Defendants;
- 4                   d. The Front Groups issued guidelines and policies minimizing the risk of
- 5                   opioid addiction and promoting opioids for chronic pain;
- 6                   e. The Front Groups strongly criticized the 2016 guidelines from the
- 7                   Center for Disease Control and Prevention (CDC) that recommended
- 8                   limits on opioid prescriptions for chronic pain; and
- 9                   f. The Front Groups concealed their connections to the KOLs and the
- 10                  RICO Marketing Defendants.

11                  581. The RICO Marketing Defendants' Front Groups, "with their large  
 12 numbers and credibility with policymakers and the public—have 'extensive  
 13 influence in specific disease areas.'" The RICO Marketing Defendants' larger  
 14 Front Groups "likely have a substantial effect on policies relevant to their industry  
 15 sponsors."<sup>398</sup> "By aligning medical culture with industry goals in this way, many  
 16 of the groups described in this report may have played a significant role in  
 17 creating the necessary conditions for the U.S. opioid epidemic."<sup>399</sup>

18                  582. The KOLs also participated, on information and belief, in the conduct  
 19 of the affairs of the Opioid Marketing Enterprise, directly or indirectly, in the  
 20 following ways:

- 21                   a. The KOLs promised to, and did, make representations regarding opioids
- 22                   and the RICO Marketing Defendants' drugs that were consistent with
- 23                   the RICO Marketing Defendants' messages themselves;

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26                  <sup>398</sup> *Fueling an Epidemic: Exposing the Financial Ties Between Opioid*  
 27 *Manufacturers and Third Party Advocacy Groups*, U.S. Senate Homeland Security  
 & Governmental Affairs Committee, Ranking Members' Office, February 12,  
 28 2018 <https://www.hslc.org/?abstract&did=808171> ("Fueling an Epidemic"), at 1.

<sup>399</sup> *Id.* 2.

- 1                   b. The KOLs distributed, through the U.S. Mail and interstate wire  
2 facilities, promotional and other materials which claimed that opioids  
3 could be safely used for chronic pain without addiction, and  
4 misrepresented the benefits of using opioids for chronic pain outweighed  
5 the risks;
- 6                   c. The KOLs echoed and amplified messages favorable to increased opioid  
7 use—and ultimately, the financial interests of the RICO Marketing  
8 Defendants;
- 9                   d. The KOLs issued guidelines and policies minimizing the risk of opioid  
10 addiction and promoting opioids for chronic pain;
- 11                  e. The KOLs strongly criticized the 2016 guidelines from the Center for  
12 Disease Control and Prevention (CDC) that recommended limits on  
13 opioid prescriptions for chronic pain; and
- 14                  f. The KOLs concealed their connections to the Front Groups and the  
15 RICO Defendants, and their sponsorship by the RICO Marketing  
16 Defendants.

17                 583. The scheme devised and implemented by the RICO Marketing  
18 Defendants and members of the Opioid Marketing Enterprise, amounted to a  
19 common course of conduct intended to increase the RICO Marketing Defendants  
20 sales from prescription opioids by encouraging the prescribing and use of opioids  
21 for long-term chronic pain. The scheme was a continuing course of conduct, and  
22 many aspects of it continue through to the present.

23                 **C. PATTERN OF RACKETEERING ACTIVITY**

24                 584. The RICO Marketing Defendants conducted and participated in the  
25 conduct of the Opioid Marketing Enterprise through a pattern of racketeering  
26 activity within the meaning of 18 U.S.C. § 1961(1) that employed the use of mail  
27 and wire facilities, in violation of 18 U.S.C. § 1341 (mail fraud) and § 1343 (wire  
28 fraud).

1       585. The RICO Marketing Defendants committed, conspired to commit,  
2 and/or aided and abetted in the commission of at least two predicate acts of  
3 racketeering activity (*i.e.* violations of 18 U.S.C. §§ 1341 and 1343) within the  
4 past ten years. The multiple acts of racketeering activity that the RICO Marketing  
5 Defendants committed, or aided and abetted in the commission of, were related to  
6 each other, posed a threat of continued racketeering activity, and therefore  
7 constitute a “pattern of racketeering activity.” The racketeering activity was made  
8 possible by the RICO Marketing Defendants’ regular use of the facilities, services,  
9 distribution channels, and employees of the Opioid Marketing Enterprise, the U.S.  
10 Mail and interstate wire facilities. The RICO Marketing Defendants participated  
11 in the scheme to defraud by using mail, telephones and the Internet to transmit  
12 mailings and wires in interstate or foreign commerce.

13       586. The pattern of racketeering activity described herein used by the  
14 RICO Marketing Defendants and the Opioid Marketing Enterprise likely involved  
15 thousands of separate instances of the use of the U.S. Mail or interstate wire  
16 facilities in furtherance of the unlawful Opioid Marketing Enterprise, including  
17 virtually uniform misrepresentations, concealments and material omissions  
18 regarding the beneficial uses and non-addictive qualities for the long-term  
19 treatment of chronic, non-acute and non-cancer pain, with the goal of profiting  
20 from increased sales of the RICO Marketing Defendants’ drugs induced by  
21 consumers, prescribers, regulators and the County’s reliance on the RICO  
22 Marketing Defendants’ misrepresentations.

23       587. Each of these fraudulent mailings and interstate wire transmissions  
24 constitutes racketeering activity and collectively, these violations constitute a  
25 pattern of racketeering activity, through which Defendants, the Front Groups and  
26 the KOLs defrauded and intended to defraud California consumers, the State, and  
27 other intended victims.

28

1       588. In devising and executing the illegal scheme, the RICO Marketing  
2 Defendants devised and knowingly carried out a material scheme and/or artifice to  
3 defraud by means of materially false or fraudulent pretenses, representations,  
4 promises, or omissions of material facts regarding the safe, non-addictive and  
5 effective use of opioids for long-term chronic, non-acute and non-cancer pain.  
6 The RICO Marketing Defendants and members of the Opioid Marketing  
7 Enterprise knew that these representations violated the FDA approved use these  
8 drugs, and were not supported by actual evidence. For the purpose of executing  
9 the illegal scheme, the RICO Marketing Defendants intended that that their  
10 common purpose and scheme to defraud would, and did, use the U.S. Mail and  
11 interstate wire facilities, intentionally and knowingly with the specific intent to  
12 advance their illegal scheme.

13       589. The RICO Marketing Defendants' predicate acts of racketeering (18  
14 U.S.C. § 1961(1)) include, but are not limited to:

- 15       a. Mail Fraud: The RICO Marketing Defendants violated 18 U.S.C. § 1341  
16           by sending or receiving, or by causing to be sent and/or received,  
17           materials via U.S. mail or commercial interstate carriers for the purpose  
18           of executing the unlawful scheme to design, manufacture, market, and  
19           sell the prescription opioids by means of false pretenses,  
20           misrepresentations, promises, and omissions.
- 21       b. Wire Fraud: The RICO Marketing Defendants violated 18 U.S.C. § 1343  
22           by transmitting and/or receiving, or by causing to be transmitted and/or  
23           received, materials by wire for the purpose of executing the unlawful  
24           scheme to design, manufacture, market, and sell the prescription opioids  
25           by means of false pretenses, misrepresentations, promises, and  
26           omissions.

27       590. Each instance of racketeering activity alleged herein was related, had  
28 similar purposes, involved the same or similar participants and methods of

1 commission, and had similar results affecting similar victims, including California  
2 consumers, prescribers, regulators and The County. The RICO Marketing  
3 Defendants, Front Groups and KOLs calculated and intentionally crafted the  
4 scheme and common purpose of the Opioid Marketing Enterprise to ensure their  
5 own profits remained high. In designing and implementing the scheme, the RICO  
6 Marketing Defendants understood and intended that those in the distribution chain  
7 rely on the integrity of the pharmaceutical companies and ostensibly neutral third  
8 parties to provide objective and scientific evidence regarding the RICO Marketing  
9 Defendants' products.

10       591. By intentionally misrepresenting the risks and benefits of using  
11 opioids for chronic pain, and then subsequently failing to disclose such practices  
12 to California consumers, prescribers, regulators and The County. Defendants, the  
13 Front Groups and the KOLs engaged in a fraudulent and unlawful course of  
14 conduct constituting a pattern of racketeering activity.

15       592. The racketeering activities conducted by the RICO Marketing  
16 Defendants, Front Groups and KOLs amounted to a common course of conduct,  
17 with a similar pattern and purpose, intended to deceive California consumers,  
18 prescribers, regulators and The County. Each separate use of the U.S. Mail and/or  
19 interstate wire facilities employed by Defendants was related, had similar intended  
20 purposes, involved similar participants and methods of execution, and had the  
21 same results affecting the same victims, including California consumers,  
22 prescribers, regulators and The County. The RICO Marketing Defendants have  
23 engaged in the pattern of racketeering activity for the purpose of conducting the  
24 ongoing business affairs of the Opioid Marketing Enterprise.

25       593. The RICO Marketing Defendants' pattern of racketeering activity  
26 alleged herein and the Opioid Marketing Enterprise are separate and distinct from  
27 each other. Likewise, the RICO Marketing Defendants are distinct from the  
28 Opioid Marketing Enterprise.

1       594. The pattern of racketeering activity alleged herein is continuing as of  
2 the date of this complaint, and, upon information and belief, will continue into the  
3 future unless enjoined by this Court.

4       595. Many of the precise dates of the Opioid Marketing Enterprise's uses  
5 of the U.S. Mail and interstate wire facilities (and corresponding predicate acts of  
6 mail and wire fraud) have been hidden and cannot be alleged without access to the  
7 books and records maintained by the RICO Marketing Defendants, Front Groups,  
8 and KOLs. Indeed, an essential part of the successful operation of the Opioid  
9 Marketing Enterprise alleged herein depended upon secrecy. However, Plaintiffs  
10 have described the occasions on which the RICO Marketing Defendants, Front  
11 Groups, and KOLs disseminated misrepresentations and false statements to  
12 California consumers, prescribers, regulators and The County, and how those acts  
13 were in furtherance of the scheme, and do so further below.

14       596. The RICO Marketing Defendants' use of the U.S. Mail and interstate  
15 wire facilities to perpetrate the opioids marketing scheme involved thousands of  
16 communications, publications, representations, statements, electronic  
17 transmissions, payments, including, *inter alia*:

- 18           a. Marketing materials about opioids, and their risks and benefits, which  
19           the RICO Marketing Defendants sent to health care providers,  
20           transmitted through the internet and television, published, and  
21           transmitted to Front Groups and KOLs located across the country and  
22           the State;
- 23           b. Written representations and telephone calls between the RICO  
24           Marketing Defendants and Front Groups regarding the  
25           misrepresentations, marketing statements and claims about opioids,  
26           including the non-addictive, safe use of chronic long-term pain  
27           generally;

- c. Written representations and telephone calls between the RICO Marketing Defendants and KOLs regarding the misrepresentations, marketing statements and claims about opioids, including the non-addictive, safe use of chronic long-term pain generally;
  - d. E-mails, telephone and written communications between the RICO Marketing Defendants and the Front Groups agreeing to or implementing the opioids marketing scheme;
  - e. E-mails, telephone and written communications between the RICO Marketing Defendants and the KOLs agreeing to or implementing the opioids marketing scheme;
  - f. Communications between the RICO Marketing Defendants, Front Groups and the media regarding publication, drafting of treatment guidelines, and the dissemination of the same as part of the Opioid Marketing Enterprise;
  - g. Communications between the RICO Marketing Defendants, KOLs and the media regarding publication, drafting of treatment guidelines, and the dissemination of the same as part of the Opioid Marketing Enterprise;
  - h. Written and oral communications directed to State agencies, federal and state courts, and private insurers throughout the State that fraudulently misrepresented the risks and benefits of using opioids for chronic pain; and
  - i. Receipts of increased profits sent through the U.S. Mail and interstate wire facilities – the wrongful proceeds of the scheme.

597. In addition to the above-referenced predicate acts, it was foreseeable to the RICO Marketing Defendants that the Front Groups and the KOLs would distribute publications through the U.S. Mail and by interstate wire facilities, and,

1 in those publications, claim that the benefits of using opioids for chronic pain  
2 outweighed the risks of doing so.

3 598. The RICO Marketing Defendants aided and abetted others in the  
4 violations of the above laws, thereby rendering them indictable as principals in the  
5 18 U.S.C. §§ 1341 and 1343 offenses.

6 599. To achieve the common goal and purpose of the Opioid Marketing  
7 Enterprise, the RICO Marketing Defendants and members of the Opioid  
8 Marketing Enterprise hid from the consumers, prescribers, regulators and The  
9 County: (1) the fraudulent nature of the RICO Marketing Defendants' marketing  
10 scheme; (2) the fraudulent nature of statements made by the RICO Marketing  
11 Defendants and by their KOLs, Front Groups and other third parties regarding the  
12 safety and efficacy of prescription opioids; and (3) the true nature of the  
13 relationship between the members of the Opioid Marketing Enterprise.

14 600. The RICO Marketing Defendants, and each member of the Opioid  
15 Marketing Enterprise agreed, with knowledge and intent, to the overall objective  
16 of the RICO Marketing Defendants' fraudulent scheme and participated in the  
17 common course of conduct to commit acts of fraud and indecency in marketing  
18 prescription opioids.

19 601. Indeed, for the RICO Marketing Defendants' fraudulent scheme to  
20 work, each of the RICO Marketing Defendants had to agree to implement similar  
21 tactics regarding fraudulent marketing of prescription opioids. This conclusion is  
22 supported by the fact that the RICO Marketing Defendants each financed,  
23 supported, and worked through the same KOLs and Front Groups, and often  
24 collaborated on and mutually supported the same publications, CMEs,  
25 presentations, and prescription guidelines.

26 602. As described herein, the RICO Marketing Defendants engaged in a  
27 pattern of related and continuous predicate acts for years. The predicate acts  
28 constituted a variety of unlawful activities, each conducted with the common

1 purpose of obtaining significant money and revenue from the marketing and sale  
2 of their highly addictive and dangerous drugs. The predicate acts also had the  
3 same or similar results, participants, victims, and methods of commission. The  
4 predicate acts were related and not isolated events.

5       603. The RICO Marketing Defendants predicate acts all had the purpose  
6 of creating the opioid epidemic that substantially injured The County's business  
7 and property, while simultaneously generating billion-dollar revenue and profits  
8 for the RICO Marketing Defendants. The predicate acts were committed or caused  
9 to be committed by the RICO Marketing Defendants through their participation in  
10 the Opioid Marketing Enterprise and in furtherance of its fraudulent scheme.

11       604. The RICO Marketing Defendants' predicate acts and pattern of  
12 racketeering activity were a substantial and foreseeable cause of The County's  
13 injury and the relationship between the RICO Marketing Defendants' conduct and  
14 The County's injury is logical and not speculative. It was foreseeable to the RICO  
15 Marketing Defendants that when they fraudulently marketed highly-addictive and  
16 dangerous drugs, that were approved for very limited and specific uses by the  
17 FDA, as non-addictive and safe for off-label uses such as moderate pain, non-  
18 cancer pain, and long-term chronic pain, that the RICO Marketing Defendants  
19 would create an opioid-addiction epidemic that logically, substantially and  
20 foreseeably harmed The County.

21       605. The pattern of racketeering activity alleged herein is continuing as of  
22 the date of this Complaint and, upon information and belief, will continue into the  
23 future unless enjoined by this Court. The last racketeering incident occurred  
24 within five years of the commission of a prior incident of racketeering.

25           **D. DAMAGES.**

26            **1. Impact of the Opioid Marketing Enterprise.**

27       606. California has been especially ravaged by the national opioid crisis.  
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1       607. More people die each year from drug overdoses in California than in  
 2 any other state.<sup>400</sup> The State's death rate has continued to climb, increasing by 30  
 3 percent from 1999 to 2015, according to the Center for Disease Control (CDC).<sup>401</sup>

4       608. In 2016, 1,925 Californians died due to prescription opioids.<sup>402</sup> This  
 5 number is on par with other recent years: in 2015, 1,966 deaths in California were  
 6 due just to prescription opioids (not including heroin); in 2014 that number was  
 7 even higher at 2,024 prescription opioid deaths; and in 2013, 1,934 Californians  
 8 died from a prescription opioid overdose.<sup>403</sup>

9       609. Of the 1,925 opioid-related deaths in California in 2016, fentanyl was  
 10 a factor in at least 234 of them.<sup>404</sup> This is an increase of 47 percent for 2016.<sup>405</sup>  
 11 Heroin-related deaths have risen by 67 percent in California since 2006.<sup>406</sup>

12       610. The high number of deaths are due in part to the extraordinary  
 13 number of opioids prescribed in the State. Over 23.6 million prescriptions for  
 14 opioids were written in California in just 2016.<sup>407</sup>

15       611. The California Department of Public Health tracks the number of  
 16 reported hospitalizations and emergency department visits due to prescription  
 17 opioids.<sup>408</sup> In 2015, the last year for which information is currently available,

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19       <sup>400</sup> Davis, *supra*.

20       <sup>401</sup> Karlamangla, *supra*.

21       <sup>402</sup> Davis, *supra*.

22       <sup>403</sup> California Department of Public Health, *California Opioid Overdose Surveillance Dashboard*, *supra*.

23       <sup>404</sup> Davis, *supra*.

24       <sup>405</sup> Karlamangla, *supra*.

25       <sup>406</sup> California Department of Public Health, *State of California Strategies to Address Prescription Drug (Opioid) Misuse, Abuse, and Overdose Epidemic in California* at 3 (June 2016), available at <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/CAOpioidPreventionStrategies4.17.pdf> (last visited March 2, 2018).

26       <sup>407</sup> California Department of Public Health, *California Opioid Overdose Surveillance Dashboard*, *supra*.

27       <sup>408</sup> *Id.*

1 California had 3,935 emergency department visits and 4,095 hospitalizations  
2 related to prescription opioid overdoses (excluding heroin).<sup>409</sup> The numbers were  
3 even higher in 2014, when 4,106 people visited the emergency department and  
4 4,482 people were hospitalized due to prescription opioid abuse.<sup>410</sup> In 2013, there  
5 were 3,964 emergency department visits and 4,344 hospitalizations for  
6 prescription opioid overdoses.<sup>411</sup> When emergency visits and hospitalizations  
7 include heroin, the numbers are even higher.<sup>412</sup>

8 612. Neonatal Abstinence Syndrome (NAS) has increased dramatically in  
9 California, with the rate of infants born with NAS more than tripling from 2008 to  
10 2013.<sup>413</sup> While the number of affected newborns rose from 1,862 in 2008 to 3,007  
11 in 2014, that number jumped by another 21 percent in 2015.<sup>414</sup> This is despite a  
12 steady decline in the overall number of births in California during that same  
13 time.<sup>415</sup>

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24 <sup>409</sup> *Id.*

25 <sup>410</sup> *Id.*

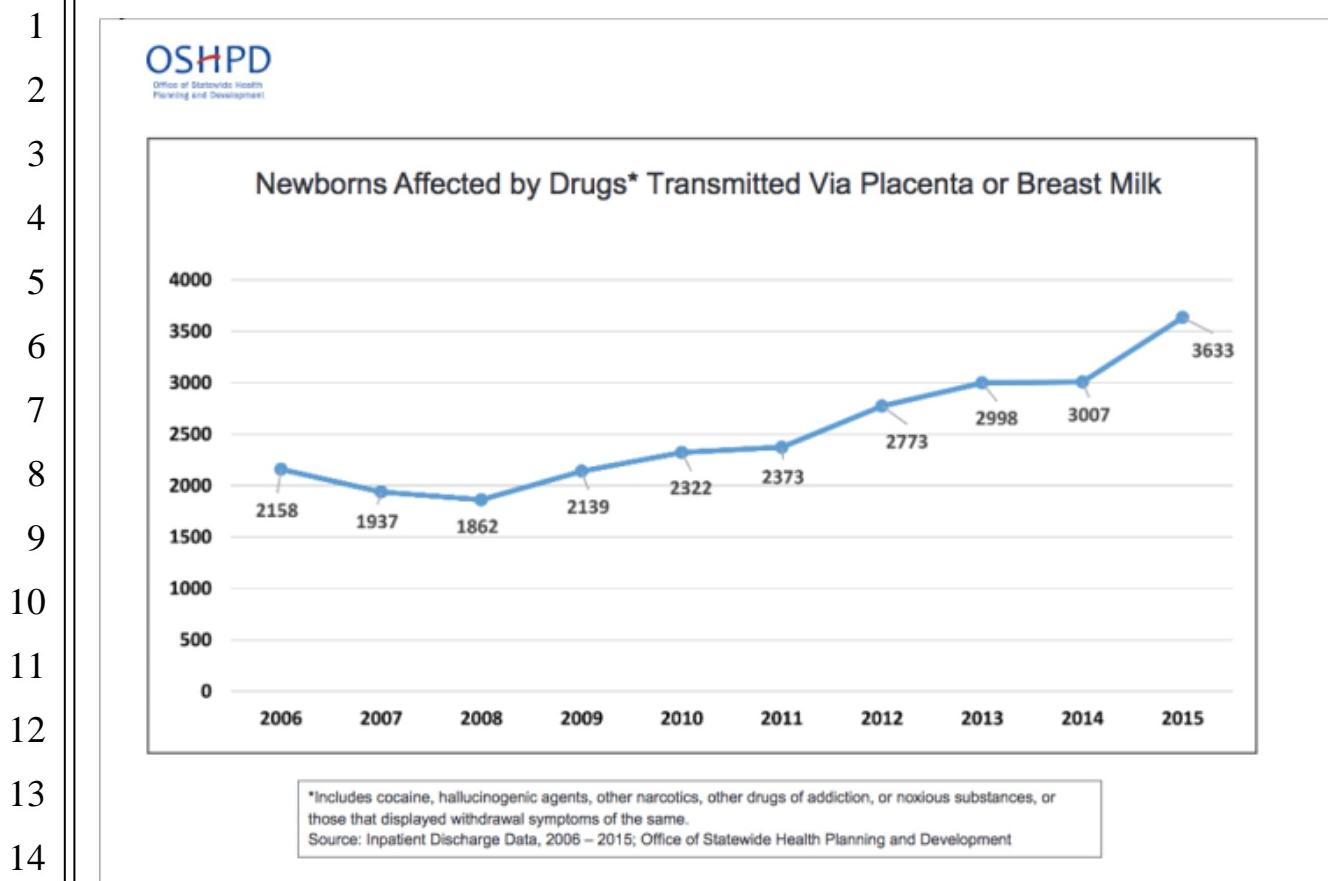
26 <sup>411</sup> *Id.*

27 <sup>412</sup> *Id.*

28 <sup>413</sup> California Child Welfare Co-Investment Partnership, *supra* at 5.

<sup>414</sup> Clark, *supra*.

<sup>415</sup> *Id.*



613. Reports from California's Office of Statewide Health Planning, which collects data from licensed health care facilities, have shown a 95 percent increase between 2008 and 2015 of newborns affected by drugs transmitted via placenta or breast milk.<sup>416</sup>

614. The opioid epidemic has also had an impact on crime in California. Pharmacy robberies have gone up by 163 percent in California over the last two years, according to the DEA. The DEA recorded 90 incidents in 2015, 154 in 2016 and, through mid-November of 2017, that number had climbed to 237.<sup>417</sup>

<sup>416</sup> California Child Welfare Co-Investment Partnership, *supra*.

<sup>417</sup> Ed Fletcher, "What's behind the spike in drug store robberies?" *The Sacramento Bee*, Dec. 8, 2017 (available at <http://www.sacbee.com/news/local/crime/article188636384.html> (last visited March 2, 2018)).

1 Most perpetrators were after prescription opioids.<sup>418</sup> In addition, fentanyl seizures  
2 at California ports increased 266 percent in fiscal year 2017.<sup>419</sup>

3 615. The opioid epidemic is particularly devastating in Plaintiffs'  
4 Community.

5 616. From 2012 to 2014, the County suffered 27 deaths due to drug  
6 overdoses, which is a drug overdose mortality rate of 14 deaths per 100,000  
7 people.<sup>420</sup>

8 617. Prescription opioids have also been responsible for a high rate of  
9 emergency department visits and hospitalizations in the County. In 2016, Tehama  
10 County had a rate of 25.2 emergency department visits due to opioid overdoses  
11 (excluding heroin), and 26.2 opioid overdose hospitalizations per 100,000  
12 residents.<sup>421</sup> That hospitalization rate was the third highest in the State that  
13 year.<sup>422</sup>

14 618. In 2016, an estimated 5.9 percent of the population aged 12 and up in  
15 Tehama County misused opioids – that is over 3,200 people in a county of just  
16 over 63,000 people – and 1.1 percent had an opioid use disorder.<sup>423</sup>

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<sup>418</sup> *Id.*

20 <sup>419</sup> United State Department of Justice, The United States Attorney's Office,  
21 Southern District of California, *U.S. Attorney Appoints Opioid Coordinators* (Feb.  
22 8, 2018) available at <https://www.justice.gov/usao-sdca/pr/us-attorney-appoints-opioid-coordinators> (last visited March 2, 2018).

23 <sup>420</sup> County Health Rankings & Roadmaps, Drug overdose deaths, available at  
24 <http://www.countyhealthrankings.org/app/california/2016/measure/factors/138/data> (last visited April 20, 2018).

25 <sup>421</sup> California Department of Public Health, *California Opioid Overdose  
Surveillance Dashboard*, available at [https://pdop.shinyapps.io/ODdash\\_v1/](https://pdop.shinyapps.io/ODdash_v1/) (last  
26 visited April 27, 2018) (Tehama County specific page).

27 <sup>422</sup> *Id.* at Statewide Table for Opioid Overdose Hospitalizations.

28 <sup>423</sup> Lisa Clemans-Cope, Marni Epstein, and Doug Wissoker, "County-Level  
Estimates of Opioid Use Disorder and Treatment Needs in California," *The Urban  
Institute*, March 19, 2018, available at  
<https://www.urban.org/sites/default/files/Tehama.pdf> (last visited April 27, 2018).

1       619. The CDC has tracked prescription rates per county in the United  
 2 States, identifying the geographic “hotspots” for rates of opioid prescriptions.<sup>424</sup>  
 3 The CDC has calculated the geographic distribution at county levels of opioid  
 4 prescriptions dispensed per 100 persons,<sup>425</sup> revealing that Tehama County has  
 5 been a consistent hotspot over at least the past decade.

6       620. The CDC’s statistics prove that the opioid prescription rates in  
 7 Tehama County have exceeded any legitimate medical, scientific, or industrial  
 8 purpose. The overall opioid prescribing rate in 2016 was 66.5 prescriptions per  
 9 100 people and 44.8 in California.<sup>426</sup> However, in Tehama County, California, the  
 10 2016 prescription rate was 94.8 per 100 people.<sup>427</sup> This is down from the 2015  
 11 prescribing rate for Tehama County which was 103.9 per 100 people – more than  
 12 one prescription for every man, woman and child in the County.<sup>428</sup>

13       621. Unfortunately, the 2015 and 2016 high rates of opioid prescriptions  
 14 were not an aberration for Tehama County. Consistently, the opioid prescribing  
 15 rates in Tehama County have been significantly greater than the national and state  
 16 averages, well more than one prescription per person living in the County and  
 17 among the highest in the State. Compared to a national average of 75.6 opioid  
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 21       <sup>424</sup> U.S. Prescribing Rate Maps, CDC, available at  
 22 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 23 2017).

24       <sup>425</sup> *Id.*

25       <sup>426</sup> *Id. See also* U.S. State Prescribing Rates, 2016, available at  
 26 <https://www.cdc.gov/drugoverdose/maps/rxstate2016.html> (last visited April 18,  
 27 2018).

28       <sup>427</sup> U.S. County Prescribing Rates, 2016, (reporting for “Tehama, CA” here and  
 29 below) CDC available at  
<https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html> (last visited April 18,  
 30 2018).

31       <sup>428</sup> U.S. County Prescribing Rates, 2015, CDC, available at  
 32 <https://www.cdc.gov/drugoverdose/maps/rxcounty2015.html> (last visited April 18,  
 33 2018).

1 prescriptions per 100 people in 2014<sup>429</sup> and 52.7 in California,<sup>430</sup> the Tehama  
 2 County opioid prescription rate was 119.4 per 100 people, almost three times the  
 3 State prescribing rate.<sup>431</sup> In 2013, the national average was 78.1 opioid  
 4 prescriptions per 100 people,<sup>432</sup> but the opioid prescription rate in Tehama County  
 5 was 121.6 per 100 people.<sup>433</sup> Compared to a national average of 81.3 opioid  
 6 prescriptions per 100 people in 2012,<sup>434</sup> the opioid prescription rate in Tehama  
 7 County was 126.9 per 100 people that year.<sup>435</sup> In 2011, the national average was  
 8 80.9 opioid prescriptions per 100 people,<sup>436</sup> but the opioid prescription rate in  
 9 Tehama County was 133.5 per 100 people.<sup>437</sup> Compared to a national average of  
 10 81.2 opioid prescriptions per 100 people in 2010,<sup>438</sup> the Tehama County opioid  
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12 <sup>429</sup> U.S. Prescribing Rate Maps, CDC, available at  
 13 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 14 2017).

15 <sup>430</sup> U.S. State Prescribing Rates, 2014, CDC, available at  
 16 <https://www.cdc.gov/drugoverdose/maps/rxstate2014.html> (last visited Dec. 11,  
 17 2017).

18 <sup>431</sup> U.S. County Prescribing Rates, 2014, CDC, available at  
 19 <https://www.cdc.gov/drugoverdose/maps/rxcounty2014.html> (last visited April 18,  
 20 2018).

21 <sup>432</sup> U.S. Prescribing Rate Maps, CDC, available at  
 22 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 23 2017).

24 <sup>433</sup> U.S. County Prescribing Rates, 2013, CDC, available at  
 25 <https://www.cdc.gov/drugoverdose/maps/rxcounty2013.html> (last visited April 18,  
 26 2018).

27 <sup>434</sup> U.S. Prescribing Rate Maps, CDC, available at  
 28 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 29 2017).

<sup>435</sup> U.S. County Prescribing Rates, 2012, CDC, available at  
<https://www.cdc.gov/drugoverdose/maps/rxcounty2012.html> (last visited April 18,  
 2018).

<sup>436</sup> U.S. Prescribing Rate Maps, CDC, available at  
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 2017).

<sup>437</sup> U.S. County Prescribing Rates, 2011, CDC, available at  
<https://www.cdc.gov/drugoverdose/maps/rxcounty2011.html> (last visited April 18,  
 2018).

<sup>438</sup> U.S. Prescribing Rate Maps, CDC, available at  
<https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 2017).

1 prescription rate was 124.6 per 100 people.<sup>439</sup> In 2009, the national average was  
 2 79.5 opioid prescriptions per 100 people,<sup>440</sup> but the rate in Tehama County was  
 3 125.6 per 100.<sup>441</sup> Compared to a national average of 78.2 opioid prescriptions per  
 4 100 people in 2008<sup>442</sup> and 55.1 in California,<sup>443</sup> the Tehama County rate was  
 5 123.6 per 100 people.<sup>444</sup> In 2007, the national average was 75.9 opioid  
 6 prescriptions per 100 people,<sup>445</sup> but the Tehama County rate was 121.3 per 100  
 7 people.<sup>446</sup> Compared to a national average of 72.4 opioid prescriptions per 100  
 8 people prescribed opioids in 2006,<sup>447</sup> the Tehama County rate was 109.4 per 100  
 9 people.<sup>448</sup>

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<sup>439</sup> U.S. County Prescribing Rates, 2010, CDC, available at <https://www.cdc.gov/drugoverdose/maps/rxcounty2010.html> (last visited April 18, 2018).

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<sup>440</sup> U.S. Prescribing Rate Maps, CDC, available at <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30, 2017).

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<sup>441</sup> U.S. County Prescribing Rates, 2009, CDC, available at <https://www.cdc.gov/drugoverdose/maps/rxcounty2009.html> (last visited April 18, 2018).

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<sup>442</sup> U.S. Prescribing Rate Maps, CDC, available at <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30, 2017).

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<sup>443</sup> U.S. State Prescribing Rates, 2008, CDC, available at <https://www.cdc.gov/drugoverdose/maps/rxstate2008.html> (last visited Dec. 11, 2017).

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<sup>444</sup> U.S. County Prescribing Rates, 2008, CDC, available at <https://www.cdc.gov/drugoverdose/maps/rxcounty2008.html> (last visited April 18, 2018).

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<sup>445</sup> U.S. Prescribing Rate Maps, CDC, available at <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,, 2017).

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<sup>446</sup> U.S. County Prescribing Rates, 2007, CDC, available at <https://www.cdc.gov/drugoverdose/maps/rxcounty2007.html> (last visited April 18, 2018).

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<sup>447</sup> U.S. Prescribing Rate Maps, CDC, available at <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30, 2017).

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<sup>448</sup> U.S. County Prescribing Rates, 2006, CDC, available at <https://www.cdc.gov/drugoverdose/maps/rxcounty2006.html> (last visited April 18, 2018).

## **2. Relief Sought.**

2       622. The RICO Marketing Defendants' violations of law and their pattern  
3 of racketeering activity directly and proximately caused The County injury in its  
4 business and property. The RICO Marketing Defendants' pattern of racketeering  
5 activity logically, substantially and foreseeably caused an opioid epidemic. The  
6 County's injuries, as described below, were not unexpected, unforeseen or  
7 independent.<sup>449</sup> Rather, as Plaintiffs allege, the RICO Marketing Defendants  
8 knew that the opioids were unsuited to treatment of long-term chronic, non-acute,  
9 and non-cancer pain, or for any other use not approved by the FDA, and knew that  
10 opioids were highly addictive and subject to abuse.<sup>450</sup> Nevertheless, the RICO  
11 Marketing Defendants engaged in a scheme of deception, that utilized the mail  
12 and wires as part of their fraud, in order to increase sales of their opioid products.

13        623. It was foreseeable and expected that a massive marketing campaign  
14 utilized by the RICO Marketing Defendants that misrepresented the non-addictive  
15 and effective use of prescription opioids for purposes for which they are not suited  
16 and not approved by the FDA would lead to a nationwide opioid epidemic.<sup>451</sup> It  
17 was also foreseeable and expected that the RICO Marketing Defendants'  
18 marketing campaign would lead to increased opioid addiction and overdose.<sup>452</sup>  
19 The County's injuries were logically, foreseeable, and substantially caused by the  
20 opioid epidemic that the RICO Marketing Defendants created.

21       624. Specifically, the RICO Marketing Defendants' predicate acts and  
22 pattern of racketeering activity caused the opioid epidemic which has injured The  
23 County in the form of substantial losses of money and property that logically,

<sup>26</sup> 449 Traveler's Property Casualty Company of America v. Actavis, Inc., 22 Cal. Rptr. 3d 5, 19 (Cal. Ct. App. 2017).

27 | 450 Id.

451 *Id.*

28 | 452 Id

1 directly and foreseeably arise from the opioid-addiction epidemic. The County's  
2 injuries, as alleged throughout this complaint, and expressly incorporated herein  
3 by reference, include:

- 4 a. Losses caused by purchasing and/or paying reimbursements for the  
5 RICO Marketing Defendants' prescription opioids, that The County  
6 would not have paid for or purchased but for the RICO Marketing  
7 Defendants' conduct;
- 8 b. Losses caused by the decrease in funding available for The County's  
9 public services for which funding was lost because it was diverted to  
10 other public services designed to address the opioid epidemic;
- 11 c. Costs for providing healthcare and medical care, additional therapeutic,  
12 and prescription drug purchases, and other treatments for patients  
13 suffering from opioid-related addiction or disease, including overdoses  
14 and deaths;
- 15 d. Costs of training emergency and/or first responders in the proper  
16 treatment of drug overdoses;
- 17 e. Costs associated with providing police officers, firefighters, and  
18 emergency and/or first responders with Naloxone – an opioid antagonist  
19 used to block the deadly effects of opioids in the context of overdose;
- 20 f. Costs associated with emergency responses by police officers,  
21 firefighters, and emergency and/or first responders to opioid overdoses;
- 22 g. Costs for providing mental-health services, treatment, counseling,  
23 rehabilitation services, and social services to victims of the opioid  
24 epidemic and their families;
- 25 h. Costs for providing treatment of infants born with opioid-related medical  
26 conditions, or born addicted to opioids due to drug use by mother during  
27 pregnancy;

- i. Costs associated with law enforcement and public safety relating to the opioid epidemic, including but not limited to attempts to stop the flow of opioids into local communities, to arrest and prosecute street-level dealers, to prevent the current opioid epidemic from spreading and worsening, and to deal with the increased levels of crimes that have directly resulted from the increased homeless and drug-addicted population;
- j. Costs associated with increased burden on the County's judicial system, including increased security, increased staff, and the increased cost of adjudicating criminal matters due to the increase in crime directly resulting from opioid addiction;
- k. Costs associated with providing care for children whose parents suffer from opioid-related disability or incapacitation;
- l. Loss of tax revenue due to the decreased efficiency and size of the working population in Plaintiffs' Community;
- m. Losses caused by diminished property values in neighborhoods where the opioid epidemic has taken root; and
- n. Losses caused by diminished property values in the form of decreased business investment and tax revenue.

625. The County's injuries were proximately caused by the RICO Marketing Defendants' racketeering activities because they were the logical, substantial and foreseeable cause of The County's injuries. But for the opioid-addiction epidemic created by the RICO Marketing Defendants' conduct, The County would not have lost money or property.

626. The County's injuries were directly caused by the RICO Marketing Defendants' pattern of racketeering activities.

627. The County is the most directly harmed entity and there is no other Plaintiff better suited to seek a remedy for the economic harms at issue here.

1       628. Plaintiff seeks all legal and equitable relief as allowed by law,  
2 including *inter alia* actual damages, treble damages, equitable relief, forfeiture as  
3 deemed proper by the Court, attorney's fees and all costs and expenses of suit and  
4 pre- and post-judgment interest.

## COUNT IV

## **RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT**

**18 U.S.C. 1961, et seq.**

**(Against Defendants Purdue, Cephalon, Endo, Mallinckrodt, Actavis,  
McKesson, Cardinal, and AmerisourceBergen)**

## **(The “Opioid Diversion Enterprise”)**

11       629. Plaintiff, The County, hereby incorporates by reference all other  
12 paragraphs of this Complaint as if fully set forth herein, and further alleges as  
13 follows.

14       630. The County brings this Claim against the following Defendants, as  
15 defined above: Purdue, Cephalon, Endo, Mallinckrodt, Actavis (the  
16 “Manufacturer Defendants”), McKesson, Cardinal, and AmerisourceBergen (the  
17 “Distributor Defendants”) (collectively, for purposes of this Claim, the “RICO  
18 Diversion Defendants”).

19       631. The RICO Diversion Defendants conducted and continue to conduct  
20 their business through legitimate and illegitimate means in the form of an  
21 association-in-fact enterprise and/or a legal entity enterprise as defined in 18  
22 U.S.C. § 1961(4). Alternatively, the RICO Diversion Defendants were members  
23 of a legal entity enterprise within the meaning of 18 U.S.C. § 1961(4).  
24 Specifically, each of the RICO Diversion Defendants was a member of the  
25 Healthcare Distribution Alliance (the “HDA”)<sup>453</sup> which is a distinct legal entity

<sup>453</sup> Health Distribution Alliance, History, Health Distribution Alliance, (last accessed on September 15, 2017), <https://www.healthcaredistribution.org/about/hda-history>.

1 that satisfies the definition of a RICO enterprise because it is a non-profit  
2 corporation and, therefore, and “enterprise” within the definition set out in 18  
3 U.S.C. § 1961(4). On information and belief, each of the RICO Diversion  
4 Defendants is a member, participant, and/or sponsor of the HDA and utilized the  
5 HDA to conduct the Opioid Diversion Enterprise and to engage in the pattern of  
6 racketeering activity that gives rise to this cause of action. The legal and  
7 association-in-fact enterprises alleged in the previous and subsequent paragraphs  
8 are pleaded in the alternative and are collectively referred to as the “Opioid  
9 Diversion Enterprise.”

10 632. For over a decade, the RICO Diversion Defendants aggressively  
11 sought to bolster their revenue, increase profit, and grow their share of the  
12 prescription painkiller market by unlawfully and surreptitiously increasing the  
13 volume of opioids they sold. However, the RICO Diversion Defendants are not  
14 permitted to engage in a limitless expansion of their sales through the unlawful  
15 sales of regulated painkillers. As “registrants” under the Controlled Substances  
16 Act, 21 U.S.C. § 821, *et seq.* (the “CSA”), the RICO Diversion Defendants  
17 operated and continue to operate within a “closed-system.” The CSA restricts the  
18 RICO Diversion Defendants’ ability to manufacture or distribute Schedule II  
19 substances like opioids by: (1) requiring them to make sales within a limited quota  
20 set by the DEA for the overall production of Schedule II substances like opioids;  
21 (2) register to manufacture or distribute opioids; (3) maintain effective controls  
22 against diversion of the controlled substances that they manufacturer or distribute;  
23 and (4) design and operate a system to identify suspicious orders of controlled  
24 substances, halt such unlawful sales, and report them to the DEA.

25 633. The closed-system created by the CSA, and the establishment of  
26 quotas, was specifically intended to reduce or eliminate the diversion of Schedule  
27 II substances like opioids from “legitimate channels of trade” to the illicit market  
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1 by controlling the “quantities of the basic ingredients needed for the manufacture  
 2 of [controlled substances].”<sup>454</sup>

3       634. Finding it impossible to legally achieve their ever increasing sales  
 4 ambitions, members of the Opioid Diversion Enterprise (defined below) engaged  
 5 in the common purpose of fraudulently increasing the quotas that governed the  
 6 manufacture and distribution of their prescription opioids. The RICO Diversion  
 7 Defendants formed and pursued their common purpose through the many personal  
 8 interactions that they had, confidentially, in organizations like the Pain Care  
 9 Forum and the Healthcare Distribution Alliance.

10      635. The RICO Diversion Defendants’ common purpose and fraudulent  
 11 scheme to unlawfully increase the DEA quotas violated the RICO Act in two  
 12 ways. First, the RICO Diversion Defendants violated the RICO Act because they  
 13 engaged in the felonious manufacture, buying selling, or otherwise dealing in  
 14 controlled substances that are punishable by law in the United States.  
 15 Specifically, the RICO Diversion Defendants “furnish[ed] false or fraudulent  
 16 material information in, or omit[ted] material information from, applications,  
 17 reports, records, and other document required to be made, kept, and filed under 21  
 18 U.S.C. §§ 801, et seq.”, in violation of 21 U.S.C. § 843(b), which is a felony.  
 19 Second, the RICO Diversion Defendants violated the RICO Act by engaging in  
 20 mail and wire fraud. The RICO Diversion Defendants common purpose and  
 21 fraudulent scheme was intended to, and did, utilize interstate mail and wire  
 22 facilities for the commission of their fraud in violation 18 U.S.C. §§ 1341 (mail  
 23 fraud) and 1343 (wire fraud).

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 26      <sup>454</sup> 1970 U.S.C.C.A.N. 4566 at 5490; *see also* Testimony of Joseph T. Rannazzisi  
 27 before the Caucus on International Narcotics Control, United States Senate, May 5,  
 28 2015 (available at [https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony\\_0.pdf](https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony_0.pdf)).

1       636. The RICO Diversion Defendants' fraudulent scheme arises at the  
2 intersection between the quotas governing the RICO Diversion Defendants'  
3 prescription opioids and the RICO Diversion Defendants' duty to identify, report,  
4 and halt suspicious orders of controlled substances. The RICO Diversion  
5 Defendants' formed an enterprise with the intent to fraudulently increase the  
6 quotas for prescription opioids by refusing to identify, report and halt suspicious  
7 orders, thereby omitting both the fact and the RICO Diversion Defendants'  
8 knowledge of widespread diversion of prescription opioids into illegitimate  
9 channels.

10      637. The RICO Diversion Defendants engaged in systematic and  
11 fraudulent acts as part of the Opioid Diversion Enterprise, that furnished false or  
12 fraudulent material information in, and omitted material information from their  
13 applications, reports, records and other documents that the RICO Defendants were  
14 required to make, keep and/or file. Furthermore, the RICO Diversion Defendants  
15 engaged in systematic and fraudulent acts as part of the Opioid Diversion  
16 Enterprise that were intended to and actually did utilize the mail and wire facilities  
17 of the United States and California, including refusing to maintain effective  
18 controls against diversion of their drugs, to design and operate a system to identify  
19 suspicious orders of their drugs, to halt unlawful sales of suspicious orders, and to  
20 notify the DEA of suspicious orders.<sup>455</sup>

21      638. Through the RICO Diversion Defendants' scheme, members of the  
22 Opioid Diversion Enterprise repeatedly requested increases of the quotas  
23 governing the manufacture, sale and distribution of prescription opioids,  
24 misrepresented that they were complying with their duties under the CSA,  
25 furnished false or fraudulent material information in, and omitted material  
26 information from their applications, reports, records and other documents,

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<sup>455</sup> 21 U.S.C. § 823(a)(1), (b)(1); 21 C.F.R. § 1301.74(b)-(c).

1 engaged in unlawful sales of painkillers that resulted in diversion of controlled  
2 substances through suspicious orders, and refused to identify or report suspicious  
3 orders of controlled substances sales to the DEA.<sup>456</sup> Defendants' refusal to report  
4 suspicious orders resulted in artificial and illegal increases in the annual  
5 production quotas for opioids allowed by the DEA. The end result of the RICO  
6 Diversion Defendants' fraudulent scheme and common purpose was continually  
7 increasing quotas that generated obscene profits and, in turn, fueled an opioid  
8 epidemic.

9       639. The RICO Diversion Defendants' illegal scheme was hatched by an  
10 enterprise between the Manufacturer Defendants and the Distributor Defendants,  
11 and executed in perfect harmony by each of them. In particular, each of the RICO  
12 Diversion Defendants were associated with, and conducted or participated in, the  
13 affairs of the Opioid Diversion Enterprise, whose common purpose was  
14 fraudulently increase the quotas governing the manufacture and sale of  
15 prescription opioids.

16       640. The success of the RICO Diversion Defendants' scheme allowed  
17 them to unlawfully increase and/or maintain high production quotas and, as a  
18 direct result, allowed them to make billions from the unlawful sale and diversion  
19 of opioids.

20       641. Simultaneously, the opioid epidemic created by the RICO Diversion  
21 Defendants' actions caused The County's multi-million dollar injuries. The  
22 County's injuries were and is a reasonably foreseeable consequence of the  
23 prescription opioid addiction epidemic that the RICO Diversion Defendants  
24 created by fraudulently increasing quotas, misrepresenting their compliance with  
25 their duties under the CSA, and allowing the widespread diversion of legally  
26 produced prescription opioids into the illicit market. As explained in detail below,

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<sup>456</sup> 21 C.F.R. § 1303.11(b); 21 C.F.R. § 1303.23.

1 the RICO Diversion Defendants' misconduct violated Section 1962(c) and the  
 2 County is entitled to treble damages for their injuries under 18 U.S.C. § 1964(c).

3       **A. THE OPIOID DIVERSION ENTERPRISE.**

4       642. Recognizing that there is a need for greater scrutiny over controlled  
 5 substances due to their potential for abuse and danger to public health and safety,  
 6 the United States Congress enacted the Controlled Substances Act in 1970.<sup>457</sup> The  
 7 CSA and its implementing regulations created a closed-system of distribution for  
 8 all controlled substances and listed chemicals.<sup>458</sup> Congress specifically designed  
 9 the closed chain of distribution to prevent the diversion of legally produced  
 10 controlled substances into the illicit market.<sup>459</sup> Congress was concerned with the  
 11 diversion of drugs out of legitimate channels of distribution and acted to halt the  
 12 "widespread diversion of [controlled substances] out of legitimate channels into  
 13 the illegal market."<sup>460</sup> Moreover, the closed-system was specifically designed to  
 14 ensure that there are multiple ways of identifying and preventing diversion  
 15 through active participation by registrants within the drug delivery chain.<sup>461</sup> All  
 16 registrants -- manufacturers and distributors alike -- must adhere to the specific  
 17 security, recordkeeping, monitoring and reporting requirements that are designed  
 18 to identify or prevent diversion.<sup>462</sup> When registrants at any level fail to fulfill their

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 20       <sup>457</sup> Joseph T. Rannazzisi Decl. ¶ 4, *Cardinal Health, Inc. v. Eric Holder, Jr., Attorney General*, D.D.C. Case No. 12-cv-185 (Document 14-2 February 10, 2012).

21       <sup>458</sup> See H.R. Rep. No. 91-1444, 1970 U.S.C.C.A.N. at 4566.

22       <sup>459</sup> *Gonzalez v. Raich*, 545 U.S. 1, 12-14 (2005); 21 U.S.C. § 801(20); 21 U.S.C. §§ 821-824, 827, 880; H.R. Rep. No. 91-1444, 1970 U.S.C.C.A.N. 4566, 4572 (Sept. 10, 1970).

23       <sup>460</sup> See Testimony of Joseph T. Rannazzisi before the Caucus on International Narcotics Control, United States Senate, May 5, 2015 (available at [https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony\\_0.pdf](https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony_0.pdf)).

24       <sup>461</sup> See Statement of Joseph T. Rannazzisi before the Caucus on International Narcotics Control United States Senate, July 18, 2012 (available at <https://www.justice.gov/sites/default/files/testimonies/witnesses/attachments/07/18/12/07-18-12-dea-rannazzisi.pdf>).

25       <sup>462</sup> Id.

1 obligations, the necessary checks and balances collapse.<sup>463</sup> The result is the  
 2 scourge of addiction that has occurred

3       643. Central to the closed-system created by the CSA was the directive  
 4 that the DEA determine quotas of each basic class of Schedule I and II controlled  
 5 substances each year. The quota system was intended to reduce or eliminate  
 6 diversion from “legitimate channels of trade” by controlling the “quantities of the  
 7 basic ingredients needed for the manufacture of [controlled substances], and the  
 8 requirement of order forms for all transfers of these drugs.”<sup>464</sup> When evaluating  
 9 production quotas, the DEA was instructed to consider the following information:

- 10           a. Information provided by the Department of Health and Human Services;
- 11           b. Total net disposal of the basic class by all manufacturers;
- 12           c. Trends in the national rate of disposal of the basic class;
- 13           d. An applicant’s production cycle and current inventory position;
- 14           e. Total actual or estimated inventories of the class and of all substances  
                 manufactured from the class and trends in inventory accumulation; and
- 15           f. Other factors such as: changes in the currently accepted medical use of  
                 substances manufactured for a basic class; the economic and physical  
                 availability of raw materials; yield and sustainability issues; potential  
                 disruptions to production; and unforeseen emergencies.<sup>465</sup>

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22       23       24       25       26       27       28  
 463 Joseph T. Rannazzisi Decl. ¶ 10, *Cardinal Health, Inc. v. Eric Holder, Jr., Attorney General*, D.D.C. Case No. 12-cv-185 (Document 14-2 February 10, 2012).

464 1970 U.S.C.C.A.N. 4566 at 5490; *see also* Testimony of Joseph T. Rannazzisi before the Caucus on International Narcotics Control, United States Senate, May 5, 2015 (available at [https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony\\_0.pdf](https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony_0.pdf)).

465 See Testimony of Joseph T. Rannazzisi before the Caucus on International Narcotics Control, United State Senate, May 5, 2015 (available at [https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony\\_0.pdf](https://www.drugcaucus.senate.gov/sites/default/files/Rannazzisi%20Testimony_0.pdf)).

1       644. It is unlawful for a registrant to manufacture a controlled substance in  
 2 Schedule II, like prescription opioids, that is (1) not expressly authorized by its  
 3 registration and by a quota assigned to it by DEA, or (2) in excess of a quota  
 4 assigned to it by the DEA.<sup>466</sup>

5       645. At all relevant times, the RICO Diversion Defendants operated as an  
 6 association-in-fact enterprise formed for the purpose of unlawfully increasing  
 7 sales, revenues and profits by fraudulently increasing the quotas set by the DEA  
 8 that would allow them to collectively benefit from a greater pool of prescription  
 9 opioids to manufacture and distribute. In support of this common purpose and  
 10 fraudulent scheme, the RICO Diversion Defendants jointly agreed to disregard  
 11 their statutory duties to identify, investigate, halt and report suspicious orders of  
 12 opioids and diversion of their drugs into the illicit market so that those orders  
 13 would not result in a decrease, or prevent an increase in, the necessary quotas.  
 14 The RICO Diversion Defendants conducted their pattern of racketeering activity  
 15 in this jurisdiction and throughout the United States through this enterprise.

16       646. The opioid epidemic has its origins in the mid-1990s when, between  
 17 1997 and 2007, per capita purchase of methadone, hydrocodone, and oxycodone  
 18 increased 13-fold, 4-fold, and 9-fold, respectively. By 2010, enough prescription  
 19 opioids were sold in the United States to medicate every adult in the country with  
 20 a dose of 5 milligrams of hydrocodone every 4 hours for 1 month.<sup>467</sup> On  
 21 information and belief, the Opioid Diversion Enterprise has been ongoing for at  
 22 least the last decade.<sup>468</sup>

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 25<sup>466</sup> *Id.* (citing 21 U.S.C. 842(b)).

26<sup>467</sup> Keyes KM, Cerdá M, Brady JE, Havens JR, Galea S. Understanding the rural-  
 27 urban differences in nonmedical prescription opioid use and abuse in the United  
 28 States. *Am J Public Health.* 2014;104(2):e52-9.

27<sup>468</sup> Matthew Perrone, [Pro-Painkiller echo chamber shaped policy amid drug epidemic](#), The Center for Public Integrity (September 19, 2017, 12:01 a.m.),  
 28 <https://www.publicintegrity.org/2016/09/19/20201/pro-painkiller-echo-chamber-shaped-policy-amid-drug-epidemic>.

1       647. The Opioid Diversion Enterprise was and is a shockingly successful  
 2 endeavor. The Opioid Diversion Enterprise has been conducting business  
 3 uninterrupted since its genesis. However, it was not until recently that federal and  
 4 state regulators finally began to unravel the extent of the enterprise and the toll  
 5 that it exacted on the American public.

6       648. At all relevant times, the Opioid Diversion Enterprise: (a) had an  
 7 existence separate and distinct from each RICO Diversion Defendant; (b) was  
 8 separate and distinct from the pattern of racketeering in which the RICO  
 9 Diversion Defendants engaged; (c) was an ongoing and continuing organization  
 10 consisting of legal entities, including each of the RICO Diversion Defendants; (d)  
 11 was characterized by interpersonal relationships among the RICO Diversion  
 12 Defendants; (e) had sufficient longevity for the enterprise to pursue its purpose;  
 13 and (f) functioned as a continuing unit.. Each member of the Opioid Diversion  
 14 Enterprise participated in the conduct of the enterprise, including patterns of  
 15 racketeering activity, and shared in the astounding growth of profits supplied by  
 16 fraudulently inflating opioid quotas and resulting sales.

17       649. The Opioid Diversion Enterprise also engaged in efforts to constrain  
 18 the DEA's authority to hold the RICO Diversion Defendants liable for  
 19 disregarding their duty to prevent diversion. Members of the Pain Care Forum  
 20 (described in greater detail below) and the Healthcare Distribution Alliance  
 21 lobbied for the passage of legislation to weaken the DEA's enforcement authority.  
 22 To this end, the Ensuring Patient Access and Effective Drug Enforcement Act  
 23 significantly reduced the DEA's ability to issue orders to show cause and to  
 24 suspend and/or revoke registrations.<sup>469</sup> The HDA and other members of the Pain  
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26       <sup>469</sup> See HDMA is now the Healthcare Distribution Alliance, Pharmaceutical  
 27 Commerce, (June 13, 2016, updated July 6, 2016),  
<http://pharmaceuticalcommerce.com/business-and-finance/hdma-now-healthcare-distribution-alliance/>; Lenny Bernstein & Scott Higham, *Investigation: The DEA Slowed Enforcement While the Opioid Epidemic Grew Out of Control*, Wash. Post, Oct. 22, 2016, <https://www.washingtonpost.com/investigations/the-dea-slowed->

1 Care Forum contributed substantial amounts of money to political campaigns for  
 2 federal candidates, state candidates, political action committees and political  
 3 parties. Upon information and belief, the Pain Care Forum and its members and  
 4 HDA, poured millions into such efforts.

5       650. The RICO Diversion Defendants, through their illegal enterprise,  
 6 engaged in a pattern of racketeering activity that involves a fraudulent scheme to  
 7 profit from the unlawful sale of prescription opioids by increasing the quotas  
 8 governing the manufacture and sale of these controlled substances. In order to  
 9 achieve that goal, the RICO Diversion Defendants knowingly allowed suspicious  
 10 orders of controlled substances to occur unhindered while millions of opioid doses  
 11 diverted into illegal markets. The end result of this strategy was exactly as the  
 12 RICO Diversion Defendants intended – artificially increased quotas for the  
 13 manufacture and distribution of opioids, all of which resulted in a National opioid  
 14 epidemic.

15       651. The Opioid Diversion Enterprise engaged in, and its activities  
 16 affected, interstate and foreign commerce because the enterprise involved  
 17 commercial activities across states lines, such as manufacture, sale, distribution,  
 18 and shipment of prescription opioids throughout the United States, and the  
 19 corresponding payment and/or receipt of money from such interstate sales.

20       652. Within the Opioid Diversion Enterprise, there were interpersonal  
 21 relationships and common communication by which the RICO Diversion  
 22 Defendants shared information on a regular basis. These interpersonal

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24 enforcement-while-the-opioid-epidemic-grew-out-of-control/2016/10/22/aea2bf8e-  
 25 7f71-11e6-8d13-d7c704ef9fd9\_story.html; Lenny Bernstein & Scott Higham,  
*Investigation: U.S. Senator Calls for Investigation of DEA Enforcement Slowdown*  
*Amid Opioid Crisis*, Wash. Post, Mar. 6, 2017,  
 26 [https://www.washingtonpost.com/investigations/us-senator-calls-for-investigation-of-dea-enforcement-slowdown/2017/03/06/5846ee60-028b-11e7-b1e9-a05d3c21f7cf\\_story.html](https://www.washingtonpost.com/investigations/us-senator-calls-for-investigation-of-dea-enforcement-slowdown/2017/03/06/5846ee60-028b-11e7-b1e9-a05d3c21f7cf_story.html); Eric Eyre, *DEA Agent: “We Had no Leadership” in WV Amid Flood of Pain Pills*, Charleston Gazette-Mail, Feb. 18, 2017,  
 27 <http://www.wvgazettemail.com/news/20170218/dea-agent-we-had-no-leadership-in-wv-amid-flood-of-pain-pills->.

1 relationships also formed the organization of the Opioid Diversion Enterprise.  
2 The Opioid Diversion Enterprise used their interpersonal relationships and  
3 communication network for the purpose of conducting the enterprise through a  
4 pattern of racketeering activity.

5       653. Each of the RICO Diversion Defendants had systematic links to each  
6 other through joint participation in trade industry organizations, contractual  
7 relationships and continuing coordination of activities. The RICO Diversion  
8 Defendants participated in the operation and management of the Opioid Diversion  
9 Enterprise by directing its affairs, as described herein. While the RICO Diversion  
10 Defendants participated in, and are members of, the enterprise, they each have a  
11 separate existence from the enterprise, including distinct legal statuses, different  
12 offices and roles, bank accounts, officers, directors, employees, individual  
13 personhood, reporting requirements, and financial statements.

14       654. The RICO Diversion Defendants exerted substantial control over the  
15 Opioid Diversion Enterprise through their membership in the Pain Care Forum,  
16 the HDA, and through their contractual relationships.

17       655. The Pain Care Forum (“PCF”) has been described as a coalition of  
18 drug makers, trade groups and dozens of non-profit organizations supported by  
19 industry funding. The PCF recently became a national news story when it was  
20 discovered that lobbyists for members of the PCF quietly shaped federal and state  
21 policies regarding the use of prescription opioids for more than a decade.

22       656. The Center for Public Integrity and The Associated Press obtained  
23 “internal documents shed[ding] new light on how drug makers and their allies  
24 shaped the national response to the ongoing wave of prescription opioid abuse.”<sup>470</sup>  
25 Specifically, PCF members spent over \$740 million lobbying in the nation’s  
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27       270 Matthew Perrone, Pro-Painkiller echo chamber shaped policy amid drug  
28       epidemic, The Center for Public Integrity (September 19, 2017, 12:01 a.m.),  
<https://www.publicintegrity.org/2016/09/19/20201/pro-painkiller-echo-chamber-shaped-policy-amid-drug-epidemic> (emphasis added).

1 capital and in all 50 statehouses on an array of issues, including opioid-related  
 2 measures.<sup>471</sup>

3       657. Not surprisingly, each of the RICO Diversion Defendants who stood  
 4 to profit from expanded prescription opioid use is a member of and/or participant  
 5 in the PCF.<sup>472</sup> In 2012, membership and participating organizations included the  
 6 HDA (of which all RICO Defendants are members), Endo, Purdue, Actavis (i.e.,  
 7 Allergan), and Teva (the parent company of Cephalon).<sup>473</sup> Each of the  
 8 Manufacturer Defendants worked together through the PCF to advance the  
 9 interests of the enterprise. But, the Manufacturer Defendants were not alone. The  
 10 Distributor Defendants actively participated, and continue to participate in the  
 11 PCF, at a minimum, through their trade organization, the HDA.<sup>474</sup> Upon  
 12 information and belief, the Distributor Defendants participated directly in the PCF  
 13 as well.

14       658. Additionally, the HDA – or Healthcare Distribution Alliance – led to  
 15 the formation of interpersonal relationships and an organization between the  
 16 RICO Diversion Defendants. Although the entire HDA membership directory is  
 17 private, the HDA website confirms that each of the Distributor Defendants and the  
 18 Manufacturer Defendants named in the Complaint, including Actavis (i.e.,  
 19 Allergan), Endo, Purdue, Mallinckrodt and Cephalon were members of the  
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21                          <sup>471</sup> *Id.*

22                          <sup>472</sup> PAIN CARE FORUM 2012 Meetings Schedule, (last updated December 2011),  
 23 <https://assets.documentcloud.org/documents/3108982/PAIN-CARE-FORUM-Meetings-Schedule-and.pdf>

24                          <sup>473</sup> *Id.* Upon information and belief, Mallinckrodt became an active member of the  
 25 PCF sometime after 2012.

26                          <sup>474</sup> *Id.* The Executive Committee of the HDA (formerly the HDMA) currently  
 27 includes the Chief Executive Officer, Pharmaceutical Segment for Cardinal Health,  
 28 Inc., the Group President, Pharmaceutical Distribution and Strategic Global Source  
 for AmerisourceBergen Corporation, and the President, U.S. Pharmaceutical for  
 McKesson Corporation. Executive Committee, Healthcare Distribution Alliance  
 (accessed on September 14, 2017),  
<https://www.healthcaredistribution.org/about/executive-committee>.

1 HDA.<sup>475</sup> Additionally, the HDA and each of the Distributor Defendants, eagerly  
 2 sought the active membership and participation of the Manufacturer Defendants  
 3 by advocating for the many benefits of members, including “strengthening . . .  
 4 alliances.”<sup>476</sup>

5       659. Beyond strengthening alliances, the benefits of HDA membership  
 6 included the ability to, among other things, “network one on one with  
 7 manufacturer executives at HDA’s members-only Business and Leadership  
 8 Conference,” “networking with HDA wholesale distributor members,”  
 9 “opportunities to host and sponsor HDA Board of Directors events,” “participate  
 10 on HDA committees, task forces and working groups with peers and trading  
 11 partners,” and “make connections.”<sup>477</sup> Clearly, the HDA and the Distributor  
 12 Defendants believed that membership in the HDA was an opportunity to create  
 13 interpersonal and ongoing organizational relationships and “alliances” between  
 14 the Manufacturers and Defendants.

15       660. The application for manufacturer membership in the HDA further  
 16 indicates the level of connection between the RICO Defendants and the level of  
 17 insight that they had into each other’s businesses.<sup>478</sup> For example, the  
 18 manufacturer membership application must be signed by a “senior company  
 19 executive,” and it requests that the manufacturer applicant identify a key contact  
 20 and any additional contacts from within its company.

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22 <sup>475</sup> Manufacturer Membership, Healthcare Distribution Alliance, (accessed on  
 23 September 14, 2017),  
<https://www.healthcaredistribution.org/about/membership/manufacturer>.

24 <sup>476</sup> Manufacturer Membership Benefits, Healthcare Distribution Alliance, (accessed  
 25 on September 14, 2017),  
<https://www.healthcaredistribution.org/~media/pdfs/membership/manufacturer-membership-benefits.ashx?la=en>.

26 <sup>477</sup> *Id.*

27 <sup>478</sup> Manufacturer Membership Application, Healthcare Distribution Alliance,  
 28 (accessed on September 14, 2017),  
<https://www.healthcaredistribution.org/~media/pdfs/membership/manufacturer-membership-application.ashx?la=en>.

1       661. The HDA application also requests that the manufacturer identify its  
 2 current distribution information, including the facility name and contact  
 3 information.

4       662. And, Manufacturer Members were asked to identify their “most  
 5 recent year end net sales” through wholesale distributors, including the Distributor  
 6 Defendants AmerisourceBergen, Cardinal Health, and McKesson and their  
 7 subsidiaries.

8       663. The closed meetings of the HDA’s councils, committees, task forces  
 9 and working groups provided the Manufacturer and Distributor Defendants with  
 10 the opportunity to work closely together, confidentially, to develop and further the  
 11 common purpose and interests of the enterprise.

12       664. The HDA also offers a multitude of conferences, including annual  
 13 business and leadership conferences. The HDA, and the Distributor Defendants  
 14 advertise these conferences to the Manufacturer Defendants as an opportunity to  
 15 “bring together high-level executives, thought leaders and influential managers . .  
 16 . to hold strategic business discussions on the most pressing industry issues.”<sup>479</sup>  
 17 The conferences also gave the Manufacturer and Distributor Defendants  
 18 “unmatched opportunities to network with [their] peers and trading partners at all  
 19 levels of the healthcare distribution industry.”<sup>480</sup> The HDA and its conferences  
 20 were significant opportunities for the Manufacturer and Distributor Defendants to  
 21 interact at a high-level of leadership. It is clear that the Manufacturer Defendants  
 22 embraced this opportunity by attending and sponsoring these events.<sup>481</sup>

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23  
 24 <sup>479</sup> Business and Leadership Conference – Information for Manufacturers,  
 Healthcare Distribution  
 25 Alliancehttps://www.healthcaredistribution.org/events/2015-business-and-  
 leadership-conference/blc-for-manufacturers (last accessed on September 14,  
 26 2017).

27       <sup>480</sup> *Id.*

28       <sup>481</sup> 2015 Distribution Management Conference and Expo, Healthcare Distribution  
 Alliance, https://www.healthcaredistribution.org/events/2015-distribution-  
 management-conference (last accessed on September 14, 2017).

1       665. Third, the RICO Diversion Defendants maintained their interpersonal  
 2 relationships by working together, through contractual chargeback arrangements,  
 3 to exchanging sales information and drive the unlawful sales of their opioids. To  
 4 this end, the Manufacturer Defendants engaged in an industry-wide practice of  
 5 paying rebates to the Distributor Defendants for sales of prescription opioids.<sup>482</sup>

6       666. For example, the *Washington Post* reported that “[o]n Aug. 23, 2011,  
 7 DEA supervisors met with Mallinckrodt executives at the agency’s headquarters  
 8 in Arlington, Va., the day a rare 5.8-magnitude earthquake hit the Washington  
 9 region. People involved in the case still call the gathering ‘the earthquake  
 10 meeting.’ DEA officials showed the company the remarkable amounts of its  
 11 oxycodone going to distributors and the number of arrests being made for  
 12 oxycodone possession and distribution on the street, according to one participant  
 13 in the meeting who also spoke on the condition of anonymity because the case is  
 14 pending.”<sup>483</sup>

15       667. “Three weeks after the Aug. 23 meeting, Mallinckrodt notified 43 of  
 16 its distributors that they would no longer receive rebates from the company if they  
 17 continued to supply certain pharmacies whose orders appeared to be  
 18 suspicious.”<sup>484</sup>

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<sup>482</sup> Lenny Bernstein & Scott Higham, The government’s struggle to hold opioid  
manufacturers accountable, The Washington Post, (April 2, 2017),  
[https://www.washingtonpost.com/graphics/investigations/dea-mallinckrodt/?utm\\_term=.b24cc81cc356](https://www.washingtonpost.com/graphics/investigations/dea-mallinckrodt/?utm_term=.b24cc81cc356); *see also*, Letter from Sen. Claire McCaskill, (July 27, 2017),  
<https://www.mccaskill.senate.gov/imo/media/image/july-opioid-investigation-letter-manufacturers.png>; Letter from Sen. Claire McCaskill, (July 27, 2017),  
<https://www.mccaskill.senate.gov/imo/media/image/july-opioid-investigation-letter-manufacturers.png>; Letters From Sen. Claire McCaskill, (March 28, 2017),  
<https://www.mccaskill.senate.gov/opioid-investigation>; Purdue Managed Markets,  
 Purdue Pharma, (accessed on September 14, 2017),  
<http://www.purduepharma.com/payers/managed-markets/>.

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 27       <sup>483</sup> [https://www.washingtonpost.com/graphics/investigations/dea-mallinckrodt/?utm\\_term=.f336835fd5da](https://www.washingtonpost.com/graphics/investigations/dea-mallinckrodt/?utm_term=.f336835fd5da)

28       <sup>484</sup> *Id.*

1       668. “On Nov. 30, 2011, the DEA served a subpoena on Mallinckrodt,  
2 demanding documents related to its suspicious-order-monitoring program,  
3 according to the company’s filings with the Securities and Exchange Commission.  
4 The subpoena brought a windfall of information. The DEA gained access to data  
5 from Mallinckrodt’s rebate or ‘chargeback’ program, an industry-wide practice  
6 that provides reimbursements to wholesale distributors. That information and  
7 other records showed where Mallinckrodt’s oxycodone was going — from the  
8 company to its network of distributors to retailers down the chain.”<sup>485</sup>

9       669. In addition, the Distributor Defendants and Manufacturer Defendants  
10 participated, through the HDA, in Webinars and other meetings designed to  
11 exchange detailed information regarding their prescription opioid sales, including  
12 purchase orders, acknowledgements, ship notices, and invoices.<sup>486</sup> For example,  
13 on April 27, 2011, the HDA offered a Webinar to “accurately and effectively  
14 exchange business transactions between distributors and manufacturers...”:

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16       670. On information and belief, the Manufacturer Defendants used this  
17 information to gather high-level data regarding overall distribution and direct the  
18 Distributor Defendants on how to most effectively sell the prescription opioids.

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27       <sup>485</sup> Id.  
28       <sup>486</sup> Webinars, Healthcare Distribution Alliance, (accessed on September 14, 2017),  
          <https://www.healthcaredistribution.org/resources/webinar-leveraging-edi>.

## 1 Webinar Leveraging EDI: Order-to-Cash 2 Transactions CD Box Set



3 (Webinar held: April 27, 2011) Using EDI to  
4 accurately and efficiently exchange business  
5 transactions (i.e., purchase orders,  
6 acknowledgements, ship notices, invoices, etc.)  
7 between distributors and manufacturers in the  
8 healthcare supply chain is critical. The  
9 development and use of voluntary guidelines  
for specific EDI standards provide industry

10 trading partners with a means to effectively convey the necessary information.

11 Hear updates on HDMA's Order-to-Cash Guidelines for Electronic Data Interchange (EDI) in the  
12 Healthcare Product Supply Chain, including the 810 Invoice; 850 Purchase Order; 855 Purchase  
13 Order Acknowledgement; and the 856 Ship Notice/Manifest.

14 671. And, through the HDA, Manufacturer Members were asked to  
15 identify their "most recent year end net sales" through wholesale distributors,  
including the Distributor Defendants as follows:

Company	Most Recent Year End Net Sales
Henry Schein, Inc.	
Henry Schein Distribution Centers (7)	
Hospital Pharmaceutical Consulting (1)	
KeySource Medical, Inc. (1)	
Louisiana Wholesale Drug Co. Inc. (1)	
McKesson Corporation (71)	
McKesson Supply Solutions (25)	
McKesson Canada (12)	
McKesson Corporation (4)	
McKesson Specialty Health (1)	
McKesson Strategic Redistribution Center (1)	
McKesson Medical Surgical (1)	
Physician Sales & Service (PSS) (25)	
US Oncology (1)	
DeVictoria Healthcare, Inc. PR (1)	
Miami-Lukens, Inc. (1)	
Morris & Dickson Co., LLC (1)	
Mutual Wholesale Drug Co. (1)	
PBA Health (1)	
Prescription Supply, Inc. (1)	
Prodigy Health Supplier Corporation (1)	
Quality Care Products, LLC (1)	
RDC (3)	
R&S Northeast LLC (2)	
Richie Pharmacal Co., LLC (1)	
Seacoast Medical LLC (1)	
Smith Drug Company, Div. JM Smith Corporation (4)	
Burlington Drug Company, Inc. (1)	
Smith Drug Company, Div. JM Smith Corporation (3)	
Top Rx (4)	
Value Drug Company (1)	
VaxServe (1)	
TOTAL SALES (millions)	\$ 0

1       672. The contractual relationships among the RICO Defendants also  
2 include vault security programs. The RICO Diversion Defendants are required to  
3 maintain certain security protocols and storage facilities for the manufacture and  
4 distribution of their opiates. Upon information and belief, the manufacturers  
5 negotiated agreements whereby the Manufacturers installed security vaults for  
6 Distributors in exchange for agreements to maintain minimum sales performance  
7 thresholds. Upon information and belief, these agreements were used by the  
8 RICO Diversion Defendants as a tool to violate their reporting and diversion  
9 duties in order to reach the required sales requirements.

10      673. Taken together, the interaction and length of the relationships  
11 between and among the Manufacturer and Distributor Defendants reflects a deep  
12 level of interaction and cooperation between two groups in a tightly knit industry.  
13 The Manufacturer and Distributor Defendants were not two separate groups  
14 operating in isolation or two groups forced to work together in a closed system.  
15 The RICO Diversion Defendants operated together as a united entity, working  
16 together on multiple fronts, to engage in the unlawful sale of prescription opioids.  
17 The HDA and the Pain Care Forum are but two examples of the overlapping  
18 relationships, and concerted joint efforts to accomplish common goals and  
19 demonstrates that the leaders of each of the RICO Diversion Defendants were in  
20 communication and cooperation.

21      674. Alternatively, the RICO Diversion Defendants were members of a  
22 legal entity enterprise within the meaning of 18 U.S.C. § 1961(4), through which  
23 the RICO Diversion Defendants conducted their pattern of racketeering activity in  
24 this jurisdiction and throughout the United States. As alleged, the Healthcare  
25 Distribution Alliance (the “HDA”)<sup>487</sup> is a distinct legal entity that satisfies the  
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<sup>487</sup> Health Distribution Alliance, History, Health Distribution Alliance, (last  
28 accessed on September 15, 2017),  
<https://www.healthcaredistribution.org/about/hda-history>.

1 definition of a RICO enterprise because it is a corporation formed under the laws  
2 of the District of Columbia, doing business in Virginia. As such, the HDA  
3 qualifies as an “enterprise” within the definition set out in 18 U.S.C. § 1961(4).

4 675. On information and belief, each of the RICO Diversion Defendants is  
5 a member, participant, and/or sponsor of the HDA, and has been since at least  
6 2006, and utilized the HDA to conduct the Opioid Diversion Enterprise and to  
7 engage in the pattern of racketeering activity that gives rise to the Count.

8 676. Each of the RICO Diversion Defendants is a legal entity separate and  
9 distinct from the HDA. Additionally, the HDA serves the interests of distributors  
10 and manufacturers beyond the RICO Diversion Defendants. Therefore, the HDA  
11 exists separately from the Opioid Diversion Enterprise, and each of the RICO  
12 Diversion Defendants exists separately from the HDA. Therefore, the HDA may  
13 serve as a RICO enterprise.

14 **B. CONDUCT OF THE OPIOID DIVERSION ENTERPRISE.**

15 677. During the time period alleged in this Complaint, the RICO  
16 Diversion Defendants exerted control over, conducted and/or participated in the  
17 Opioid Diversion Enterprise by fraudulently claiming that they were complying  
18 with their duties under the CSA to identify, investigate and report suspicious  
19 orders of opioids in order to prevent diversion of those highly addictive substances  
20 into the illicit market, and to halt such unlawful sales, so as to increase production  
21 quotas and generate unlawful profits, as follows:

22 678. Defendants disseminated false and misleading statements to state and  
23 federal regulators claiming that (1) the quotas for prescription opioids should be  
24 increased, (2) they were complying with their obligations to maintain effective  
25 controls against diversion of their prescription opioids, (3) they were complying  
26 with their obligations to design and operate a system to disclose to the registrant  
27 suspicious orders of their prescription opioids, (4) they were complying with their  
28 obligation to notify the DEA of any suspicious orders or diversion of their

1 prescription opioids and (5) they did not have the capability to identify suspicious  
 2 orders of controlled substances despite their possession of national, regional, state,  
 3 and local prescriber- and patient-level data that allowed them to track prescribing  
 4 patterns over time, which the Defendants obtained from data companies, including  
 5 but not limited to: IMS Health, QuintilesIMS, Iqvia, Pharmaceutical Data  
 6 Services, Source Healthcare Analytics, NDS Health Information Services,  
 7 Verispan, Quintiles, SDI Health, ArcLight, Scriptline, Wolters Kluwer, and/or  
 8 PRA Health Science, and all of their predecessors or successors in interest (the  
 9 “Data Vendors”).

10       679. The RICO Diversion Defendants applied political and other pressure  
 11 on the DOJ and DEA to halt prosecutions for failure to report suspicious orders of  
 12 prescription opioids and lobbied Congress to strip the DEA of its ability to  
 13 immediately suspend registrations pending investigation by passing the “Ensuring  
 14 Patient Access and Effective Drug Enforcement Act.”<sup>488</sup>

15       680. The Distributor Defendants developed “know your customer”  
 16 questionnaires and files. This information, compiled pursuant to comments from  
 17 the DEA in 2006 and 2007 was intended to help the RICO Diversion Defendants  
 18 identify suspicious orders or customers who were likely to divert prescription  
 19  
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21       <sup>488</sup> See HDMA is now the Healthcare Distribution Alliance, Pharmaceutical  
 22 Commerce, (June 13, 2016, updated July 6, 2016),  
<http://pharmaceuticalcommerce.com/business-and-finance/hdma-now-healthcare-distribution-alliance/>; Lenny Bernstein & Scott Higham, *Investigation: The DEA Slowed Enforcement While the Opioid Epidemic Grew Out of Control*, Wash. Post, Oct. 22, 2016, [https://www.washingtonpost.com/investigations/the-dea-slowed-enforcement-while-the-opioid-epidemic-grew-out-of-control/2016/10/22/aea2bf8e-7f71-11e6-8d13-d7c704ef9fd9\\_story.html](https://www.washingtonpost.com/investigations/the-dea-slowed-enforcement-while-the-opioid-epidemic-grew-out-of-control/2016/10/22/aea2bf8e-7f71-11e6-8d13-d7c704ef9fd9_story.html); Lenny Bernstein & Scott Higham, *Investigation: U.S. Senator Calls for Investigation of DEA Enforcement Slowdown Amid Opioid Crisis*, Wash. Post, Mar. 6, 2017, [https://www.washingtonpost.com/investigations/us-senator-calls-for-investigation-of-dea-enforcement-slowdown/2017/03/06/5846ee60-028b-11e7-b1e9-a05d3c21f7cf\\_story.html](https://www.washingtonpost.com/investigations/us-senator-calls-for-investigation-of-dea-enforcement-slowdown/2017/03/06/5846ee60-028b-11e7-b1e9-a05d3c21f7cf_story.html); Eric Eyre, *DEA Agent: “We Had no Leadership” in WV Amid Flood of Pain Pills*, Charleston Gazette-Mail, Feb. 18, 2017, <http://www.wvgazettemail.com/news/20170218/dea-agent-we-had-no-leadership-in-wv-amid-flood-of-pain-pills->.

1       opioids.<sup>489</sup> On information and belief, the “know your customer” questionnaires  
 2 informed the RICO Diversion Defendants of the number of pills that the  
 3 pharmacies sold, how many non-controlled substances are sold compared to  
 4 controlled substances, whether the pharmacy buys from other distributors, the  
 5 types of medical providers in the area, including pain clinics, general practitioners,  
 6 hospice facilities, cancer treatment facilities, among others, and these  
 7 questionnaires put the recipients on notice of suspicious orders.

8           681. The RICO Diversion Defendants purchased nationwide, regional,  
 9 state, and local prescriber- and patient-level data from the Data Vendors that  
 10 allowed them to track prescribing trends, identify suspicious orders, identify  
 11 patients who were doctor shopping, identify pill mills, etc. The Data Vendors’  
 12 information purchased by the RICO Diversion Defendants allowed them to view,  
 13 analyze, compute, and track their competitors sales, and to compare and analyze  
 14 market share information.<sup>490</sup>

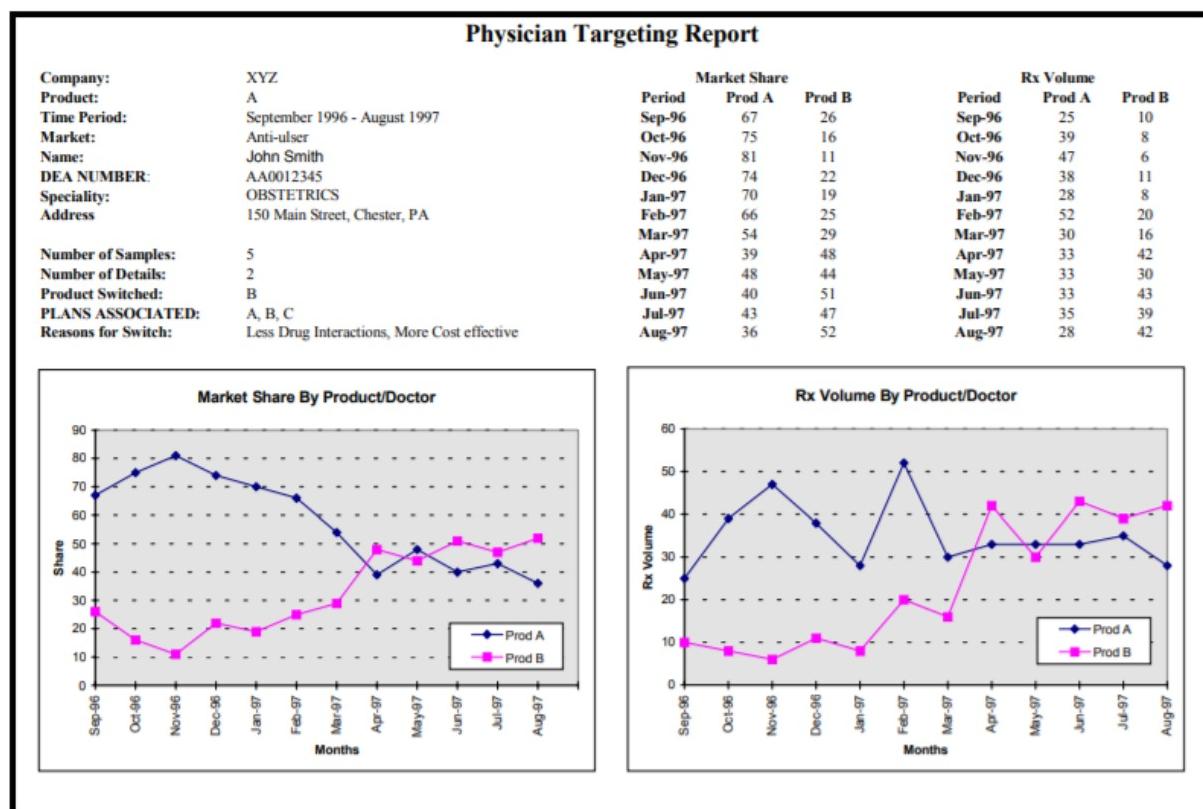
15           682. IMS, for example, IMS provided the RICO Diversion Defendants  
 16 with reports detailing prescriber behavior and the number of prescriptions written  
 17 between competing products.<sup>491</sup>

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 21       <sup>489</sup> Suggested Questions a Distributor should ask prior to shipping controlled  
 22 substances, Drug Enforcement Administration (available at  
[https://www.deadiversion.usdoj.gov/mtgs/pharm\\_industry/14th\\_pharm/levin1 ques.pdf](https://www.deadiversion.usdoj.gov/mtgs/pharm_industry/14th_pharm/levin1 ques.pdf)); Richard Widup, Jr., Kathleen H. Dooley, Esq. Pharmaceutical Production  
 23 Diversion: Beyond the PDMA, Purdue Pharma and McGuireWoods LLC,  
 24 (available at [https://www.mcguirewoods.com/news-](https://www.mcguirewoods.com/news-resources/publications/lifesciences/product_diversion_beyond_pdma.pdf)  
 resources/publications/lifesciences/product\_diversion\_beyond\_pdma.pdf).

25       <sup>490</sup> A Verispan representative testified that the RICO Defendants use the  
 26 prescribing information to “drive market share.” *Sorrell v. IMS Health Inc.*, 2011  
 27 WL 661712, \*9-10 (Feb. 22, 2011).

28       <sup>491</sup> Paul Kallukaran & Jerry Kagan, *Data Mining at IMS HEALTH: How we Turned*  
*a Mountain of Data into a Few Information-rich Molehills*, (accessed on February  
 15, 2018),  
<http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.198.349&rep=rep1&type=pdf>, Figure 2 at p.3.

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Figure 2:

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16        683. Similarly, Wolters Kluwer, an entity that eventually owned data  
17 mining companies that were created by McKesson (Source) and Cardinal Health  
18 (ArcLight), provided the RICO Defendants with charts analyzing the weekly  
19 prescribing patterns of multiple physicians, organized by territory, regarding  
20 competing drugs, and analyzed the market share of those drugs.<sup>492</sup>

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492 *Sorrell v. IMS Health Inc.*, 2011 WL 705207, \*467-471 (Feb. 22, 2011).

1. The Prescriber Roster shows Prescriber demographics, prescribing information and indicator arrows

Territory : 1102		Weekly Prescriber TR					
Prescriber	Trend	Specialty	Product	WEEK Feb-03-06	WEEK Jan-27-06	WEEK Jan-20-06	WEEK Jan-13-06
Territory : 1102 – TOTAL			PRODUCT A	46	64	58	88
			PRODUCT B	292	253	247	278
			PRODUCT C	55	56	56	58
			PRODUCT D	36	28	34	33
			PRODUCT E	7	9	2	9
			PRODUCT F	1	3	5	0
Doctor A		IM	PRODUCT A	4	1	1	1
			PRODUCT B	2	2	2	3
			PRODUCT C	0	2	0	0
			PRODUCT D	0	0	0	0
			PRODUCT E	0	0	0	0
			PRODUCT F	0	0	0	0
Doctor B		GE	PRODUCT A	3	1	1	2
			PRODUCT B	5	4	7	2
			PRODUCT C	0	1	0	0
			PRODUCT D	0	0	0	0
			PRODUCT E	0	1	0	1
			PRODUCT F	0	0	0	0
Doctor C		GE	PRODUCT A	3	1	2	0
			PRODUCT B	4	5	0	3
			PRODUCT C	0	1	1	0
			PRODUCT D	0	1	0	2
			PRODUCT E	0	0	0	0
			PRODUCT F	0	0	0	0

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3. Territory Summary Report shows Prescriber Roster information aggregated at a territory level

## Territory Summary

Name	Spec	Zip	Product A NRX	Product A MM Share	Product A Rank	Market NRX	Market Rank
ABNEY, RAY C.	P	05302	6	10.7%	43	56	38
ALLISTER, ROBERT	P	03820	6	18.8%	43	32	63
ALTMAN, LEE S.	P	01655	34	14.0%	3	247	3
BALLARD, HARLOW	P	05801	0	0.0%	93	8	96
BARNEY, CHRISTINE A.	P	03766	6	26.1%	43	23	85
BARTON, GAIL	P	03755	13	32.5%	18	40	50
BERNSTEIN, RICHARD A.	P	05401	0	0.0%	93	14	94
BOHNERI, MICHAEL	P	03060	3	4.5%	73	66	29
BOSTIC, JEFFERY O.	CHP	03079	5	10.9%	55	45	44
BREITHOLTZ, TIMOTHY	P	03870	13	34.2%	18	38	52
BROWN, KENNETH	P	03941	4	10.0%	61	40	50
BUCHANAN, KEVIN	P	05701	5	16.1%	55	31	70
CARMAN, MEGAN W.	P	03246	10	12.3%	28	81	18
CARSEN, MARJORIA	P	05701	6	18.2%	43	33	59
CATPANO-FRIEDMAN, LISA	P	05201	5	8.6%	43	70	25
CLARKE-RUBIN, LORNA	P	12901	8	24.2%	32	33	59
COHEN, DEVRA H.	CHP	03060	3	6.5%	73	46	44
COLE, STEPHEN A.	P	05101	5	13.2%	55	38	52
COTTON, PAUL G.	P	05401	13	28.3%	18	46	44
CUSI, PRISCILLA M.	P	03104	17	7.9%	14	215	5
DAVISON, MARTHA F.	P	03110	14	11.3%	16	124	8
DEJONG, JACOB	P	03067	0	0.0%	93	21	87
DELFAUSSE, PETER O.	P	03301	6	35.3%	43	17	90
DENNETT, DOUGLAS E.	CHP	05401	0	0.0%	93	33	59
DEPPE, SUSAN L.	P	05401	1	0.3%	87	300	2
DEVENDERRAO, T.	P	03060	7	9.6%	37	73	21

684. This information allowed the RICO Diversion Defendants to track and identify instances of, overprescribing.<sup>493</sup> In fact, one of the Data Venders' experts testified that a manufacturer of "narcotic analgesics" used the Data Venders' information to track, identify, report and halt suspicious orders of controlled substances.<sup>494</sup>

<sup>493</sup> See *Sorrell v. IMS Health Inc.*, 2011 WL 1449043, \*37-38 (March 24, 2011) (arguing that data had been used to “identify overuse of antibiotics in children,” and “whether there is a wide use of anthrax prophylactic medicines after the scares happened in 2001.”). The Data Vender Respondents also cited evidence from the trial court proving that “because analysis of PI data makes it possible to ‘identify overuse of a pharmaceutical in specific conditions, the government employs the data to monitor usage of controlled substances.’” *Id.*

<sup>494</sup> *Id.* at \*38. Eugene "Mick" Kolassa testified as an expert on behalf of the Data Vender stating that "a firm that sells narcotic analgesics was able to use prescriber-identifiable information to identify physicians that seemed to be prescribing an

1 [455] Q. Besides marketing and promotion, are  
2 there any other uses for prescriber-identifiable data?

3 A. There's a number of other uses.

4 Q. And what are those?

5 A. The one that I was most impressed with  
6 was a firm that used it to identify - a firm that  
7 sells narcotic analgesics was able to use prescriber-  
8 identifiable information to identify physicians that  
9 seemed to be prescribing an inordinately high num-  
10 ber of prescriptions for their product and they would  
11 use that to notify the DEA and other authorities of  
12 potential problems.

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14 685. The RICO Diversion Defendants were, therefore, collectively aware  
15 of the suspicious orders that flowed daily from their manufacturing and  
16 distribution facilities.

17 686. The RICO Diversion Defendants refused to identify, investigate and  
18 report suspicious orders to the DEA when they became aware of the same despite  
19 their actual knowledge of drug diversion rings. The RICO Diversion Defendants  
20 refused to identify suspicious orders and diverted drugs despite the DEA issuing  
21 final decisions against the Distributor Defendants in 178 registrant actions  
22 between 2008 and 2012<sup>495</sup> and 117 recommended decision in registrant actions  
23 from The Office of Administrative Law Judges. These numbers include seventy-  
24 six (76) actions involving orders to show cause and forty-one (41) actions

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26 inordinately high number of prescriptions for their product." *Id*; see also Joint  
27 Appendix in *Sorrell v. IMS Health*, 2011 WL 687134, at \*204 (Feb. 22, 2011).

28 <sup>495</sup> Evaluation and Inspections Div., Office of the Inspector Gen., U.S. Dep't of  
Justice, *The Drug Enforcement Administration's Adjudication of Registrant Actions* 6 (2014), <https://oig.justice.gov/reports/2014/e1403.pdf>.

1 involving immediate suspension orders – all for failure to report suspicious  
2 orders.<sup>496</sup>

3       687. Defendants' scheme had a decision-making structure driven by the  
4 Manufacturer Defendants and corroborated by the Distributor Defendants. The  
5 Manufacturer Defendants worked together to control the State and Federal  
6 Government's response to the manufacture and distribution of prescription opioids  
7 by increasing production quotas through a systematic refusal to maintain effective  
8 controls against diversion, and identify suspicious orders and report them to the  
9 DEA.

10      688. The RICO Diversion Defendants worked together to control the flow  
11 of information and influence state and federal governments and political  
12 candidates to pass legislation that was pro-opioid. The Manufacturer and  
13 Distributor Defendants did this through their participation in the PCF and HDA.

14      689. The RICO Diversion Defendants also worked together to ensure that  
15 the Aggregate Production Quotas, Individual Quotas and Procurement Quotas  
16 allowed by the DEA remained artificially high and ensured that suspicious orders  
17 were not reported to the DEA in order to ensure that the DEA had no basis for  
18 refusing to increase or decrease production quotas due to diversion. The RICO  
19 Diversion Defendants influenced the DEA production quotas in the following  
20 ways:

21      690. The scheme devised and implemented by the RICO Diversion  
22 Defendants amounted to a common course of conduct characterized by a refusal to  
23 maintain effective controls against diversion, and all designed and operated to  
24 ensure the continued unlawful sale of controlled substances.

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<sup>496</sup> Id.

1                   **C. PATTERN OF RACKETEERING ACTIVITY.**

2                   691. The RICO Diversion Defendants conducted and participated in the  
3 conduct of the Opioid Diversion Enterprise through a pattern of racketeering  
4 activity as defined in 18 U.S.C. § 1961(1)(D), including ; the felonious  
5 manufacture, importation, receiving, concealment buying selling, or otherwise  
6 dealing in a controlled substance or listed chemical (as defined in section 102 of  
7 the Controlled Substance Act), punishable under any law of the United States; and  
8 18 U.S.C. 1961(1)(B), including mail fraud (18 U.S.C. § 1341) and wire fraud (18  
9 U.S.C. § 1343).

10                  **1. The RICO Defendants Manufactured, Sold and/or Dealt  
11                   in Controlled Substances and Their Actions Constitute  
12                   Crimes Punishable as Felonies.**

13                  692. The RICO Diversion Defendants conducted and participated in the  
14 conduct of the affairs of the Opioid Diversion Enterprise through a pattern of  
15 racketeering activity as defined in 18 U.S.C. § 1961(1)(D) by the felonious  
16 manufacture, importation, receiving, concealment, buying, selling, or otherwise  
17 dealing in a controlled substance or listed chemical (as defined in section 102 of  
18 the Controlled Substance Act), punishable under any law of the United States.

19                  693. The RICO Diversion Defendants committed crimes that are  
20 punishable as felonies under the laws of the United States. Specifically, 21 U.S.C.  
21 § 843(a)(4) makes it unlawful for any person to knowingly or intentionally furnish  
22 false or fraudulent information in, or omit any material information from, any  
23 application, report, record or other document required to be made, kept or filed  
24 under this subchapter. A violation of section 843(a)(4) is punishable by up to four  
25 years in jail, making it a felony. 21 U.S.C. § 843(d)(1).

26                  694. Each of the RICO Diversion Defendants qualifies as a registrant  
27 under the CSA. Their status as registrants under the CSA requires that they  
28 maintain effective controls against diversion of controlled substances in schedule I

1 or II, design and operate a system to disclose to the registrant suspicious orders of  
2 controlled substances and inform the DEA of suspicious orders when discovered  
3 by the registrant. 21 U.S.C. § 823; 21 C.F.R. § 1301.74(b).

4 695. The CSA and the Code of Federal Regulations, require the RICO  
5 Diversion Defendants to make reports to the DEA of any suspicious orders  
6 identified through the design and operation of their system to disclose suspicious  
7 orders. The failure to make reports as required by the CSA and Code of Federal  
8 Regulations amounts to a criminal violation of the statute.

9 696. The RICO Diversion Defendants knowingly and intentionally  
10 furnished false or fraudulent information in their reports to the DEA about  
11 suspicious orders, and/or omitted material information from reports, records and  
12 other document required to be filed with the DEA including the Manufacturer  
13 Defendants' applications for production quotas. Specifically, the RICO Diversion  
14 Defendants were aware of suspicious orders of prescription opioids and the  
15 diversion of their prescription opioids into the illicit market, and failed to report  
16 this information to the DEA in their mandatory reports and their applications for  
17 production quotas.

18 697. Upon information and belief, the foregoing examples reflect the  
19 RICO Diversion Defendants' pattern and practice of willfully and intentionally  
20 omitting information from their mandatory reports to the DEA as required by 21  
21 C.F.R. § 1301.74. The sheer volume of enforcement actions available in the  
22 public record against the Distributor Defendants supports this conclusion.<sup>497</sup> For  
23 example:

24 698. On April 24, 2007, the DEA issued an *Order to Show Cause and*  
25 *Immediate Suspension Order* against the AmerisourceBergen Orlando, Florida

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<sup>497</sup> Evaluation and Inspections Div., Office of the Inspector Gen., U.S. Dep't of  
Justice, *The Drug Enforcement Administration's Adjudication of Registrant Actions* 6 (2014), <https://oig.justice.gov/reports/2014/e1403.pdf>.

1 distribution center (“Orlando Facility”) alleging failure to maintain effective  
2 controls against diversion of controlled substances. On June 22, 2007,  
3 AmerisourceBergen entered into a settlement that resulted in the suspension of its  
4 DEA registration.

5 699. On November 28, 2007, the DEA issued an *Order to Show Cause*  
6 and *Immediate Suspension Order* against the Cardinal Health Auburn,  
7 Washington Distribution Center (“Auburn Facility”) for failure to maintain  
8 effective controls against diversion of hydrocodone.

9 700. On December 5, 2007, the DEA issued an *Order to Show Cause and*  
10 *Immediate Suspension Order* against the Cardinal Health Lakeland, Florida  
11 Distribution Center (“Lakeland Facility”) for failure to maintain effective controls  
12 against diversion of hydrocodone.

13 701. On December 7, 2007, the DEA issued an *Order to Show Cause and*  
14 *Immediate Suspension Order* against the Cardinal Health Swedesboro, New Jersey  
15 Distribution Center (“Swedesboro Facility”) for failure to maintain effective controls  
16 against diversion of hydrocodone.

17 702. On January 30, 2008, the DEA issued an *Order to Show Cause and*  
18 *Immediate Suspension Order* against the Cardinal Health Stafford, Texas  
19 Distribution Center (“Stafford Facility”) for failure to maintain effective controls  
20 against diversion of hydrocodone.

21 703. On May 2, 2008, McKesson Corporation entered into an  
22 *Administrative Memorandum of Agreement* (“2008 MOA”) with the DEA which  
23 provided that McKesson would “maintain a compliance program designed to  
24 detect and prevent the diversion of controlled substances, inform DEA of  
25 suspicious orders required by 21 C.F.R. § 1301.74(b), and follow the procedures  
26 established by its Controlled Substance Monitoring Program.”

27 704. On September 30, 2008, Cardinal Health entered into a *Settlement*  
28 and *Release Agreement and Administrative Memorandum of Agreement* with the

1 DEA related to its Auburn Facility, Lakeland Facility, Swedesboro Facility and  
2 Stafford Facility. The document also referenced allegations by the DEA that  
3 Cardinal failed to maintain effective controls against the diversion of controlled  
4 substances at its distribution facilities located in McDonough, Georgia  
5 (“McDonough Facility”), Valencia, California (“Valencia Facility”) and Denver,  
6 Colorado (“Denver Facility”).

7 705. On February 2, 2012, the DEA issued an *Order to Show Cause and*  
8 *Immediate Suspension Order* against the Cardinal Health Lakeland, Florida  
9 Distribution Center (“Lakeland Facility”) for failure to maintain effective controls  
10 against diversion of oxycodone.

11 706. On May, 14, 2012, Cardinal Health entered into an Administrative  
12 Memorandum of Agreement with the DEA in which, among other things,  
13 Cardinal Health “admits that its due diligence efforts for some pharmacy  
14 customers and its compliance with the 2008 MOA, in certain respects, were  
15 inadequate.”

16 707. Thereafter, on December 23, 2016, Cardinal Health agreed to pay a  
17 \$44 million fine to the DEA to resolve the civil penalty portion of the  
18 administrative action taken against its Lakeland, Florida Distribution Center.

19 708. On January 5, 2017, McKesson Corporation entered into an  
20 *Administrative Memorandum Agreement* with the DEA wherein it agreed to pay a  
21 \$150,000,000 civil penalty for violation of the 2008 MOA as well as failure to  
22 identify and report suspicious orders at its facilities in Aurora CO, Aurora IL,  
23 Delran NJ, LaCrosse WI, Lakeland FL, Landover MD, La Vista NE, Livonia MI,  
24 Methuen MA, Santa Fe Springs CA, Washington Courthouse OH and West  
25 Sacramento CA.

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28

1       709. In its Administrative Memorandum Agreement, McKesson  
2 acknowledged its wrongdoing and failure to comply with the obligations imposed  
3 by the CSA:

4       2. Acceptance of Responsibility. On or about September 27, 2006, February 7, 2007 and  
5 December 27, 2007, DEA's Deputy Assistant Administrator, Office of Diversion Control, sent  
6 letters to every entity in the United States that was registered with DEA to manufacture or  
7 distribute controlled substances, including McKesson (the "DEA Letters"). The DEA Letters  
8 contained, among other things, guidance for the identification and reporting of suspicious orders  
9 to DEA, as required by 21 C.F.R. § 1301.74(b). McKesson acknowledges that, at various times  
10 during the period from January 1, 2009 up through and including the Effective Date of this  
11 Agreement (the "Covered Time Period"), it did not identify or report to DEA certain orders  
12 placed by certain pharmacies which should have been detected by McKesson as suspicious based  
13 on the guidance contained in the DEA Letters about the requirements set forth in 21 C.F.R. §  
14 1301.74(b) and 21 U.S.C. § 842(a)(5). McKesson has taken steps to prevent such conduct from  
15 occurring in the future, including the measures delineated in the Compliance Addendum.  
16

17       On or about May 2, 2008, DEA and McKesson entered into an Administrative  
18 Memorandum of Agreement (the "2008 MOA"). The 2008 MOA provided among other things,  
19 that McKesson maintain a compliance program designed to detect and prevent the diversion of  
20 controlled substances, inform DEA of suspicious orders as required by 21 C.F.R. § 1301.74(b),  
21 and follow procedures established by its Controlled Substance Monitoring Program ("CSMP").  
22 McKesson acknowledges that, at various times during the Covered Time Period, it did not  
23 identify or report to DEA certain orders placed by certain pharmacies, which should have been  
24 detected by McKesson as suspicious, in a manner fully consistent with the requirements set forth  
25 in the 2008 MOA. McKesson has taken steps to prevent such conduct from occurring in the  
26 future, including the measures delineated in the Compliance Addendum.

27       710. On April 23, 2015, McKesson filed a Form-8-K announcing a  
28 settlement with the DEA and DOJ wherein it admitted to violating the CSA and  
agreed to pay \$150 million and have some of its DEA registrations suspended on a  
staggered basis.

29       711. In 2016, the Los Angeles Times reported that Purdue was aware of a  
30 pill mill operating out of Los Angeles yet failed to alert the DEA. The LA Times  
31 uncovered that Purdue began tracking a surge in prescriptions in Los Angeles,  
32 including one prescriber in particular. Documents published by the L.A. Times  
33 reveal that a Purdue sales manager spoke with company officials, asking:  
34

35       712. Purdue was clearly aware of diversion. As a registrant, Purdue has  
36 the same obligation to report suspicious orders as a wholesale distributor.  
37 Although Purdue claimed that it was considering making a report to the DEA, it  
38

1 shirked its responsibility, claimed that it was the wholesaler's responsibility and  
2 then reserved the right to make the report:

3       713. Despite its knowledge of obvious diversion, "Purdue did not shut off  
4 the supply of highly addictive OxyContin and did not tell authorities what it knew  
5 about [a pill mill] until several years later when the clinic was out of business and  
6 its leaders indicted. By that time, 1.1 million pills had spilled into the hands of  
7 Armenian mobsters, the Crips gang and other criminals."

8       714. Finally, Mallinckrodt was recently the subject of a DEA and Senate  
9 investigation for its opioid practices. Specifically, in 2011, the DEA targeted  
10 Mallinckrodt arguing that it ignored its responsibility to report suspicious orders  
11 as 500 million of its pills ended up in Florida between 2008 and 2012. After six  
12 years of DEA investigation, Mallinckrodt agreed to a settlement involving a \$35  
13 million fine. Federal prosecutors summarized the case by saying that  
14 Mallinckrodt's response was that everyone knew what was going on in Florida but  
15 they had no duty to report it.

16       715. These actions against the Distributor Defendants confirm that the  
17 Distributor Defendants knew they had a duty to maintain effective controls against  
18 diversion, design and operate a system to disclose suspicious orders, and to report  
19 suspicious orders to the DEA. These actions also demonstrate, on information and  
20 belief, that the Manufacturer Defendants were aware of the enforcement against  
21 their Distributors and the diversion of the prescription opioids and a  
22 corresponding duty to report suspicious orders.

23       716. The pattern of racketeering activity alleged herein is continuing as of  
24 the date of this Complaint and, upon information and belief, will continue into the  
25 future unless enjoined by this Court.

26       717. Many of the precise dates of the RICO Diversion Defendants'  
27 criminal actions at issue herein were hidden and cannot be alleged without access  
28 to their books and records. Indeed, an essential part of the successful operation of

1 the Opioid Diversion Enterprise depended upon the secrecy of the participants in  
2 that enterprise.

3       718. Each instance of racketeering activity alleged herein was related, had  
4 similar purposes, involved the same or similar participants and methods of  
5 commission, and had similar results affecting similar victims, Plaintiffs'  
6 Community and the County. Defendants calculated and intentionally crafted the  
7 diversion scheme to increase and maintain profits from unlawful sales of opioids,  
8 without regard to the effect such behavior would have on this jurisdiction, its  
9 citizens or the County. The Defendants were aware that the County and the  
10 citizens of this jurisdiction rely on the Defendants to maintain a closed system of  
11 manufacturing and distribution to protect against the non-medical diversion and  
12 use of their dangerously addictive opioid drugs.

13       719. By intentionally refusing to report and halt suspicious orders of their  
14 prescription opioids, Defendants engaged in a fraudulent scheme and unlawful  
15 course of conduct constituting a pattern of racketeering activity.

16       720. The RICO Diversion Defendants' predicate acts and pattern of  
17 racketeering activity were a substantial and foreseeable cause of the County's  
18 injury and the relationship between the RICO Diversion Defendants' conduct and  
19 the County's injury are logical and not speculative. It was foreseeable to the  
20 RICO Diversion Defendants that when they refused to identify, report and halt  
21 suspicious orders as required by the CSA and Code of Federal Regulations, it  
22 would allow the wide-spread diversion of prescriptions opioids into the illicit  
23 market and create an opioid-addiction epidemic that logically, substantially, and  
24 foreseeably harmed the County.

25       721. The RICO Diversion Defendants' predicate acts and pattern of  
26 racketeering activity were a substantial and foreseeable cause of the County's  
27 injury and the relationship between the RICO Diversion Defendants' conduct and  
28 the County's injury is logical and not speculative. It was foreseeable to the RICO

1 Diversion Defendants that when they fraudulently marketed highly-addictive and  
2 dangerous drugs, that were approved for very limited and specific uses by the  
3 FDA, as non-addictive and safe for off-label uses such as moderate pain, non-  
4 cancer pain, and long-term chronic pain, that the RICO Diversion Defendants  
5 would create an opioid-addiction epidemic that logically, substantially and  
6 foreseeably harmed the County.

7 722. The last racketeering incident occurred within five years of the  
8 commission of a prior incident of racketeering.

9 **2. The RICO Diversion Defendants Engaged in Mail and  
10 Wire Fraud.**

11 723. The RICO Diversion Defendants carried out, or attempted to carry  
12 out, a scheme to defraud federal and state regulators, and the American public by  
13 knowingly conducting or participating in the conduct of the Opioid Diversion  
14 Enterprise through a pattern of racketeering activity within the meaning of 18  
15 U.S.C. § 1961(1) that employed the use of mail and wire facilities, in violation of  
16 18 U.S.C. § 1341 (mail fraud) and § 1343 (wire fraud).

17 724. The RICO Diversion Defendants committed, conspired to commit,  
18 and/or aided and abetted in the commission of at least two predicate acts of  
19 racketeering activity (*i.e.* violations of 18 U.S.C. §§ 1341 and 1343) within the  
20 past ten years. The multiple acts of racketeering activity that the RICO Diversion  
21 Defendants committed, or aided and abetted in the commission of, were related to  
22 each other, posed a threat of continued racketeering activity, and therefore  
23 constitute a “pattern of racketeering activity.” The racketeering activity was made  
24 possible by the RICO Diversion Defendants’ regular use of the facilities, services,  
25 distribution channels, and employees of the Opioid Diversion Enterprise. The  
26 RICO Diversion Defendants participated in the scheme to defraud by using mail,  
27 telephone and the Internet to transmit mailings and wires in interstate or foreign  
28 commerce.

1       725. The RICO Diversion Defendants used, directed the use of, and/or  
2 caused to be used, thousands of interstate mail and wire communications in  
3 service of their scheme through virtually uniform misrepresentations,  
4 concealments and material omissions regarding their compliance with their  
5 mandatory reporting requirements and the actions necessary to carry out their  
6 unlawful goal of selling prescription opioids without reporting suspicious orders  
7 or the diversion of opioids into the illicit market.

8       726. In devising and executing the illegal scheme, the RICO Diversion  
9 Defendants devised and knowingly carried out a material scheme and/or artifice to  
10 defraud by means of materially false or fraudulent pretenses, representations,  
11 promises, or omissions of material facts. For the purpose of executing the illegal  
12 scheme, the RICO Diversion Defendants committed these racketeering acts,  
13 which number in the thousands, intentionally and knowingly with the specific  
14 intent to advance the illegal scheme.

15       727. The RICO Diversion Defendants' predicate acts of racketeering (18  
16 U.S.C. § 1961(1)) include, but are not limited to:

- 17       a. Mail Fraud: The RICO Defendants violated 18 U.S.C. § 1341 by  
18 sending or receiving, or by causing to be sent and/or received, materials  
19 via U.S. mail or commercial interstate carriers for the purpose of  
20 executing the unlawful scheme to design, manufacture, market, and sell  
21 the prescription opioids by means of false pretenses, misrepresentations,  
22 promises, and omissions.
- 23       b. Wire Fraud: The RICO Defendants violated 18 U.S.C. § 1343 by  
24 transmitting and/or receiving, or by causing to be transmitted and/or  
25 received, materials by wire for the purpose of executing the unlawful  
26 scheme to design, manufacture, market, and sell the prescription opioids  
27 by means of false pretenses, misrepresentations, promises, and  
28 omissions.

1       728. The RICO Diversion Defendants' use of the mail and wires includes,  
2 but is not limited to, the transmission, delivery, or shipment of the following by  
3 the Manufacturers, Distributors, or third parties that were foreseeably caused to be  
4 sent as a result of the RICO Diversion Defendants' illegal scheme, including but  
5 not limited to:

- 6       a. The prescription opioids themselves;
- 7       b. Documents and communications that supported and/or facilitated the  
8              Defendants' request for higher aggregate production quotas, individual  
9              production quotas, and procurement quotas;
- 10      c. Documents and communications that facilitated the manufacture,  
11              purchase and sale of prescription opioids;
- 12      d. Defendants' DEA registrations;
- 13      e. Documents and communications that supported and/or facilitated  
14              Defendants' DEA registrations;
- 15      f. Defendants' records and reports that were required to be submitted to the  
16              DEA pursuant to 21 U.S.C. § 827;
- 17      g. Documents and communications related to the Defendants' mandatory  
18              DEA reports pursuant to 21 U.S.C. § 823 and 21 C.F.R. § 1301.74;
- 19      h. Documents intended to facilitate the manufacture and distribution of  
20              Defendants' prescription opioids, including bills of lading, invoices,  
21              shipping records, reports and correspondence;
- 22      i. Documents for processing and receiving payment for prescription  
23              opioids;
- 24      j. Payments from the Distributors to the Manufacturers;
- 25      k. Rebates and chargebacks from the Manufacturers to the Distributors;
- 26      l. Payments to Defendants' lobbyists through the PCF;
- 27      m. Payments to Defendants' trade organizations, like the HDA, for  
28              memberships and/or sponsorships;

- 1                   n. Deposits of proceeds from Defendants' manufacture and distribution of  
 2                   prescription opioids; and  
 3                   o. Other documents and things, including electronic communications.

4                   729. On information and belief, the RICO Diversion Defendants (and/or  
 5                   their agents), for the purpose of executing the illegal scheme, sent and/or received  
 6                   (or caused to be sent and/or received) by mail or by private or interstate carrier,  
 7                   shipments of prescription opioids and related documents by mail or by private  
 8                   carrier affecting interstate commerce, including the following:

Defendant Group Name	Company Names	Drugs		
		Drug Name	Chemical Name	CSA Schedule
Purdue	(1) Purdue Pharma, LP, (2) Purdue Pharma, Inc., (3) The Purdue Frederick Company	OxyContin	Oxycodone hydrochloride extended release	Schedule II
		MS Contin	Morphine sulfate extended release	Schedule II
		Dilaudid	Hydromorphone hydrochloride	Schedule II
		Dilaudid-HP	Hydromorphone hydrochloride	Schedule II
		Butrans	Buprenorphine	Schedule II
		Hysinga ER	Hydrocodone bitrate	Schedule II
		Targiniq ER	Oxycodone hydrochloride	Schedule II
Cephalon	(1) Cephalon, Inc., (2) Teva Pharmaceutical Industries, Ltd., (3) Teva Pharmaceuticals USA, Inc.	Actiq	Fentanyl citrate	Schedule II
		Fentora	Fentanyl citrate	Schedule II
		Generic oxycontin	Oxycodone hydrochloride	Schedule II
Endo	(1) Endo Health Solutions, Inc., (2) Endo Pharmaceuticals Inc., (3) Qualitest Pharmaceuticals, Inc. (wholly-owned subsidiary of Endo)	Opana ER	Oxymorphone hydrochloride extended release	Schedule II
		Opana	Oxymorphone hydrochloride	Schedule II
		Percodan	Oxymorphone hydrochloride and aspirin	Schedule II
		Percocet	Oxymorphone hydrochloride and acetaminophen	Schedule II
		Generic oxycodone		Schedule II
		Generic oxymorphone		Schedule II

Defendant Group Name	Company Names	Drugs		
		Drug Name	Chemical Name	CSA Schedule
		Generic hydromorphone		Schedule II
Mallinckrodt	(1) Mallinckrodt PLC, (2) Mallinckrodt LLC (wholly-owned subsidiary of Mallinckrodt PLC)	Exalgo	Hydromorphone hydrochloride	Schedule II
		Roxicodone	Oxycodone hydrochloride	Schedule II
Allergan	(1) Allergan Plc, (2) Actavis LLC, (3) Actavis Pharma, Inc., (4) Actavis Plc, (5) Actavis, Inc., (6) Watson Pharmaceuticals, Inc., (7) Watson Pharma, Inc.	Kadian	Morphine Sulfate	Schedule II
		Norco (Generic of Kadian)	Hydrocodone and acetaminophen	Schedule II
		Generic Duragesic	Fentanyl	Schedule II
		Generic Opana	Oxymorphone hydrochloride	Schedule II

730. Each of the RICO Diversion Defendants identified manufactured, shipped, paid for and received payment for the drugs identified above, throughout the United States.

731. The RICO Diversion Defendants also used the internet and other electronic facilities to carry out their scheme and conceal the ongoing fraudulent activities. Specifically, the RICO Diversion Defendants made misrepresentations about their compliance with Federal and State laws requiring them to identify, investigate and report suspicious orders of prescription opioids and/or diversion of the same into the illicit market.

732. At the same time, the RICO Diversion Defendants misrepresented the superior safety features of their order monitoring programs, ability to detect suspicious orders, commitment to preventing diversion of prescription opioids, and their compliance with all state and federal regulations regarding the identification and reporting of suspicious orders of prescription opioids.

733. Upon information and belief, the RICO Diversion Defendants utilized the internet and other electronic resources to exchange communications,

1 to exchange information regarding prescription opioid sales, and to transmit  
2 payments and rebates/chargebacks.

3       734. The RICO Diversion Defendants also communicated by U.S. Mail,  
4 by interstate facsimile, and by interstate electronic mail with each other and with  
5 various other affiliates, regional offices, regulators, distributors, and other third-  
6 party entities in furtherance of the scheme.

7       735. The mail and wire transmissions described herein were made in  
8 furtherance of Defendants' scheme and common course of conduct to deceive  
9 regulators, the public and The County that Defendants were complying with their  
10 state and federal obligations to identify and report suspicious orders of  
11 prescription opioids all while Defendants were knowingly allowing millions of  
12 doses of prescription opioids to divert into the illicit drug market. The RICO  
13 Diversion Defendants' scheme and common course of conduct was to increase or  
14 maintain high production quotas for their prescription opioids from which they  
15 could profit.

16       736. Many of the precise dates of the fraudulent uses of the U.S. mail and  
17 interstate wire facilities have been deliberately hidden by Defendants and cannot  
18 be alleged without access to Defendants' books and records. However, Plaintiffs  
19 have described the types of, and in some instances, occasions on which the  
20 predicate acts of mail and/or wire fraud occurred. They include thousands of  
21 communications to perpetuate and maintain the scheme, including the things and  
22 documents described in the preceding paragraphs.

23       737. The RICO Diversion Defendants did not undertake the practices  
24 described herein in isolation, but as part of a common scheme. Various other  
25 persons, firms, and corporations, including third-party entities and individuals not  
26 named as defendants in this Complaint, may have contributed to and/or  
27 participated in the scheme with the RICO Diversion Defendants in these offenses  
28 and have performed acts in furtherance of the scheme to increase revenues,

1 increase market share, and /or minimize the losses for the RICO Diversion  
2 Defendants.

3       738. The RICO Diversion Defendants aided and abetted others in the  
4 violations of the above laws, thereby rendering them indictable as principals in the  
5 18 U.S.C. §§ 1341 and 1343 offenses.

6       739. The RICO Diversion Defendants hid from the general public and  
7 suppressed and/or ignored warnings from third parties, whistleblowers and  
8 governmental entities about the reality of the suspicious orders that the RICO  
9 Diversion Defendants were filling on a daily basis – leading to the diversion of  
10 hundreds of millions of doses of prescriptions opioids into the illicit market.

11       740. The RICO Diversion Defendants, with knowledge and intent, agreed  
12 to the overall objective of their fraudulent scheme and participated in the common  
13 course of conduct to commit acts of fraud and indecency in manufacturing and  
14 distributing prescription opioids.

15       741. Indeed, for the Defendants' fraudulent scheme to work, each of the  
16 Defendants had to agree to implement similar tactics regarding manufacturing  
17 prescription opioids and refusing to report suspicious orders.

18       742. As described herein, the RICO Diversion Defendants engaged in a  
19 pattern of related and continuous predicate acts for years. The predicate acts  
20 constituted a variety of unlawful activities, each conducted with the common  
21 purpose of obtaining significant monies and revenues from the sale of their highly  
22 addictive and dangerous drugs. The predicate acts also had the same or similar  
23 results, participants, victims, and methods of commission. The predicate acts were  
24 related and not isolated events.

25       743. The predicate acts all had the purpose of creating the opioid epidemic  
26 that substantially injured the County's business and property, while  
27 simultaneously generating billion-dollar revenue and profits for the RICO  
28 Diversion Defendants. The predicate acts were committed or caused to be

1 committed by the RICO Diversion Defendants through their participation in the  
2 Opioid Diversion Enterprise and in furtherance of its fraudulent scheme.

3       744. The pattern of racketeering activity alleged herein and the Opioid  
4 Diversion Enterprise are separate and distinct from each other. Likewise,  
5 Defendants are distinct from the enterprise.

6       745. The pattern of racketeering activity alleged herein is continuing as of  
7 the date of this Complaint and, upon information and belief, will continue into the  
8 future unless enjoined by this Court.

9       746. Many of the precise dates of the RICO Diversion Defendants'  
10 criminal actions at issue here have been hidden by Defendants and cannot be  
11 alleged without access to Defendants' books and records. Indeed, an essential part  
12 of the successful operation of the Opioid Diversion Enterprise alleged herein  
13 depended upon secrecy.

14       747. Each instance of racketeering activity alleged herein was related, had  
15 similar purposes, involved the same or similar participants and methods of  
16 commission, and had similar results affecting similar victims, including Plaintiffs'  
17 Community and the County. Defendants calculated and intentionally crafted the  
18 Opioid Diversion Enterprise and their scheme to increase and maintain their  
19 increased profits, without regard to the effect such behavior would have on  
20 Plaintiffs' Community, its citizens or the County. In designing and implementing  
21 the scheme, at all times Defendants were cognizant of the fact that those in the  
22 manufacturing and distribution chain rely on the integrity of the pharmaceutical  
23 companies and ostensibly neutral third parties to provide objective and reliable  
24 information regarding Defendants' products and their manufacture and  
25 distribution of those products. The Defendants were also aware that The County  
26 and the citizens of this jurisdiction rely on the Defendants to maintain a closed  
27 system and to protect against the non-medical diversion and use of their  
28 dangerously addictive opioid drugs.

1       748. By intentionally refusing to report and halt suspicious orders of their  
2 prescription opioids, Defendants engaged in a fraudulent scheme and unlawful  
3 course of conduct constituting a pattern of racketeering activity.

4       749. It was foreseeable to Defendants that The County would be harmed  
5 when they refused to report and halt suspicious orders, because their violation of  
6 the duties imposed by the CSA and Code of Federal Regulations allowed the  
7 widespread diversion of prescription opioids out of appropriate medical channels  
8 and into the illicit drug market – causing the opioid epidemic that the CSA  
9 intended to prevent.

10      750. The last racketeering incident occurred within five years of the  
11 commission of a prior incident of racketeering.

12      **D. DAMAGES.**

13           **1. Impact of the Opioid Diversion Enterprise.**

14      751. California has been especially ravaged by the national opioid crisis.

15      752. More people die each year from drug overdoses in California than in  
16 any other state.<sup>498</sup> The State's death rate has continued to climb, increasing by 30  
17 percent from 1999 to 2015, according to the Center for Disease Control (CDC).<sup>499</sup>

18      753. In 2016, 1,925 Californians died due to prescription opioids.<sup>500</sup> This  
19 number is on par with other recent years: in 2015, 1,966 deaths in California were  
20 due just to prescription opioids (not including heroin); in 2014 that number was  
21 even higher at 2,024 prescription opioid deaths; and in 2013, 1,934 Californians  
22 died from a prescription opioid overdose.<sup>501</sup>

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<sup>498</sup> Davis, *supra*.

26      <sup>499</sup> Karlamangla, *supra*.

27      <sup>500</sup> Davis, *supra*.

28      <sup>501</sup>California Department of Public Health, *California Opioid Overdose Surveillance Dashboard*, available at [https://pdop.shinyapps.io/ODdash\\_v1/](https://pdop.shinyapps.io/ODdash_v1/) (last visited March 2, 2018).

1       754. Of the 1,925 opioid-related deaths in California in 2016, fentanyl was  
 2 a factor in at least 234 of them.<sup>502</sup> This is an increase of 47 percent for 2016.<sup>503</sup>  
 3 Heroin-related deaths have risen by 67 percent in California since 2006.<sup>504</sup>

4       755. The high number of deaths are due in part to the extraordinary  
 5 number of opioids prescribed in the State. Over 23.6 million prescriptions for  
 6 opioids were written in California in just 2016.<sup>505</sup>

7       756. The California Department of Public Health tracks the number of  
 8 reported hospitalizations and emergency department visits due to prescription  
 9 opioids.<sup>506</sup> In 2015, the last year for which information is currently available,  
 10 California had 3,935 emergency department visits and 4,095 hospitalizations  
 11 related to prescription opioid overdoses (excluding heroin).<sup>507</sup> The numbers were  
 12 even higher in 2014, when 4,106 people visited the emergency department and  
 13 4,482 people were hospitalized due to prescription opioid abuse.<sup>508</sup> In 2013, there  
 14 were 3,964 emergency department visits and 4,344 hospitalizations for  
 15 prescription opioid overdoses.<sup>509</sup> When emergency visits and hospitalizations  
 16 include heroin, the numbers are even higher.<sup>510</sup>

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 20       <sup>502</sup> Davis, *supra*.

21       <sup>503</sup> Karlamangla, *supra*.

22       <sup>504</sup> California Department of Public Health, *State of California Strategies to*  
 23 *Address Prescription Drug (Opioid) Misuse, Abuse, and Overdose Epidemic in*  
 24 *California* at 3 (June 2016), available at  
<https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Prescription%20Drug%20Overdose%20Program/CAOpioidPreventionStrategies4.17.pdf> (last visited March 2, 2018).

25       <sup>505</sup> California Department of Public Health, *California Opioid Overdose*  
*Surveillance Dashboard*, *supra*.

26       <sup>506</sup> *Id.*

27       <sup>507</sup> *Id.*

28       <sup>508</sup> *Id.*

29       <sup>509</sup> *Id.*

30       <sup>510</sup> *Id.*

1       757. NAS has increased dramatically in California, with the rate of infants  
 2 born with NAS more than tripling from 2008 to 2013.<sup>511</sup> While the number of  
 3 affected newborns rose from 1,862 in 2008 to 3,007 in 2014, that number jumped  
 4 by another 21 percent in 2015.<sup>512</sup> This is despite a steady decline in the overall  
 5 number of birth in California during that same time.<sup>513</sup>

6       758. Reports from California's Office of Statewide Health Planning,  
 7 which collects data from licensed health care facilities, have shown a 95 percent  
 8 increase between 2008 and 2015 of newborns affected by drugs transmitted via  
 9 placenta or breast milk.<sup>514</sup>

10      759. The opioid epidemic has also had an impact on crime in California.  
 11 Pharmacy robberies have gone up by 163 percent in California over the last two  
 12 years, according to the DEA. The DEA recorded 90 incidents in 2015, 154 in  
 13 2016 and, through mid-November of 2017, that number had climbed to 237.<sup>515</sup>  
 14 Most perpetrators were after prescription opioids.<sup>516</sup> In addition, fentanyl seizures  
 15 at California ports increased 266 percent in fiscal year 2017.<sup>517</sup>

16      760. The opioid epidemic is particularly devastating in Plaintiffs'  
 17 Community.

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21      <sup>511</sup> California Child Welfare Co-Investment Partnership, *supra* at 5.

22      <sup>512</sup> Clark, *supra*.

23      <sup>513</sup> *Id.*

24      <sup>514</sup> California Child Welfare Co-Investment Partnership, *supra*.

25      <sup>515</sup> Ed Fletcher, "What's behind the spike in drug store robberies?" *The Sacramento Bee*, Dec. 8, 2017 (available at <http://www.sacbee.com/news/local/crime/article188636384.html> (last visited March 2, 2018)).

26      <sup>516</sup> *Id.*

27      <sup>517</sup> United State Department of Justice, The United States Attorney's Office,  
 28 Southern District of California, *U.S. Attorney Appoints Opioid Coordinators* (Feb. 8, 2018) available at <https://www.justice.gov/usao-sdca/pr/us-attorney-appoints-opioid-coordinators> (last visited March 2, 2018).

1       761. From 2012 to 2014, the County suffered 27 deaths due to drug  
 2 overdoses, which is a drug overdose mortality rate of 14 deaths per 100,000  
 3 people.<sup>518</sup>

4       762. Prescription opioids have also been responsible for a high rate of  
 5 emergency department visits and hospitalizations in the County. In 2016, Tehama  
 6 County had a rate of 25.2 emergency department visits due to opioid overdoses  
 7 (excluding heroin), and 26.2 opioid overdose hospitalizations per 100,000  
 8 residents.<sup>519</sup> That hospitalization rate was the third highest in the State that  
 9 year.<sup>520</sup>

10      763. In 2016, an estimated 5.9 percent of the population aged 12 and up in  
 11 Tehama County misused opioids – that is over 3,200 people in a county of just  
 12 over 63,000 people – and 1.1 percent had an opioid use disorder.<sup>521</sup>

13      764. The CDC has tracked prescription rates per county in the United  
 14 States, identifying the geographic “hotspots” for rates of opioid prescriptions.<sup>522</sup>  
 15 The CDC has calculated the geographic distribution at county levels of opioid  
 16 prescriptions dispensed per 100 persons,<sup>523</sup> revealing that Tehama County has  
 17 been a consistent hotspot over at least the past decade.

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20      <sup>518</sup> County Health Rankings & Roadmaps, Drug overdose deaths, available at  
 21 <http://www.countyhealthrankings.org/app/california/2016/measure/factors/138/data> (last visited April 20, 2018).

22      <sup>519</sup> California Department of Public Health, *California Opioid Overdose*  
 23 *Surveillance Dashboard*, available at [https://pdop.shinyapps.io/ODdash\\_v1/](https://pdop.shinyapps.io/ODdash_v1/) (last  
 24 visited April 27, 2018) (Tehama County specific page).

25      <sup>520</sup> *Id.* at Statewide Table for Opioid Overdose Hospitalizations.

26      <sup>521</sup> Lisa Clemans-Cope, Marni Epstein, and Doug Wissoker, “County-Level  
 27 Estimates of Opioid Use Disorder and Treatment Needs in California,” *The Urban*  
 28 *Institute*, March 19, 2018, available at <https://www.urban.org/sites/default/files/Tehama.pdf> (last visited April 27, 2018).

29      <sup>522</sup> U.S. Prescribing Rate Maps, CDC, available at  
 30 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 31 2017).

32      <sup>523</sup> *Id.*

1       765. The CDC's statistics prove that the opioid prescription rates in  
 2 Tehama County have exceeded any legitimate medical, scientific, or industrial  
 3 purpose. The overall opioid prescribing rate in 2016 was 66.5 prescriptions per  
 4 100 people and 44.8 in California.<sup>524</sup> However, in Tehama County, California, the  
 5 2016 prescription rate was 94.8 per 100 people.<sup>525</sup> This is down from the 2015  
 6 prescribing rate for Tehama County which was 103.9 per 100 people – more than  
 7 one prescription for every man, woman and child in the County.<sup>526</sup>

8       766. Unfortunately, the 2015 and 2016 high rates of opioid prescriptions  
 9 were not an aberration for Tehama County. Consistently, the opioid prescribing  
 10 rates in Tehama County have been significantly greater than the national and state  
 11 averages, well more than one prescription per person living in the County and  
 12 among the highest in the State. Compared to a national average of 75.6 opioid  
 13 prescriptions per 100 people in 2014<sup>527</sup> and 52.7 in California,<sup>528</sup> the Tehama  
 14 County opioid prescription rate was 119.4 per 100 people, almost three times the  
 15 State prescribing rate.<sup>529</sup> In 2013, the national average was 78.1 opioid  
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18       <sup>524</sup> *Id.* See also U.S. State Prescribing Rates, 2016, available at  
 19 <https://www.cdc.gov/drugoverdose/maps/rxstate2016.html> (last visited April 18,  
 2018).

20       <sup>525</sup> U.S. County Prescribing Rates, 2016, (reporting for "Tehama, CA" here and  
 21 below) CDC available at  
<https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html> (last visited April 18,  
 2018).

22       <sup>526</sup> U.S. County Prescribing Rates, 2015, CDC, available at  
 23 <https://www.cdc.gov/drugoverdose/maps/rxcounty2015.html> (last visited April 18,  
 2018).

24       <sup>527</sup> U.S. Prescribing Rate Maps, CDC, available at  
 25 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 2017).

26       <sup>528</sup> U.S. State Prescribing Rates, 2014, CDC, available at  
 27 <https://www.cdc.gov/drugoverdose/maps/rxstate2014.html> (last visited Dec. 11,  
 2017).

28       <sup>529</sup> U.S. County Prescribing Rates, 2014, CDC, available at  
<https://www.cdc.gov/drugoverdose/maps/rxcounty2014.html> (last visited April 18,  
 2018).

1 prescriptions per 100 people,<sup>530</sup> but the opioid prescription rate in Tehama County  
 2 was 121.6 per 100 people.<sup>531</sup> Compared to a national average of 81.3 opioid  
 3 prescriptions per 100 people in 2012,<sup>532</sup> the opioid prescription rate in Tehama  
 4 County was 126.9 per 100 people that year.<sup>533</sup> In 2011, the national average was  
 5 80.9 opioid prescriptions per 100 people,<sup>534</sup> but the opioid prescription rate in  
 6 Tehama County was 133.5 per 100 people.<sup>535</sup> Compared to a national average of  
 7 81.2 opioid prescriptions per 100 people in 2010,<sup>536</sup> the Tehama County opioid  
 8 prescription rate was 124.6 per 100 people.<sup>537</sup> In 2009, the national average was  
 9 79.5 opioid prescriptions per 100 people,<sup>538</sup> but the rate in Tehama County was  
 10 125.6 per 100.<sup>539</sup> Compared to a national average of 78.2 opioid prescriptions per

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<sup>530</sup> U.S. Prescribing Rate Maps, CDC, available at  
 12 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 13 2017).

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<sup>531</sup> U.S. County Prescribing Rates, 2013, CDC, available at  
 15 <https://www.cdc.gov/drugoverdose/maps/rxcounty2013.html> (last visited April 18,  
 16 2018).

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<sup>532</sup> U.S. Prescribing Rate Maps, CDC, available at  
 18 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 19 2017).

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<sup>533</sup> U.S. County Prescribing Rates, 2012, CDC, available at  
 21 <https://www.cdc.gov/drugoverdose/maps/rxcounty2012.html> (last visited April 18,  
 22 2018).

23

<sup>534</sup> U.S. Prescribing Rate Maps, CDC, available at  
 24 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 25 2017).

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<sup>535</sup> U.S. County Prescribing Rates, 2011, CDC, available at  
 27 <https://www.cdc.gov/drugoverdose/maps/rxcounty2011.html> (last visited April 18,  
 28 2018).

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<sup>536</sup> U.S. Prescribing Rate Maps, CDC, available at  
 30 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 31 2017).

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<sup>537</sup> U.S. County Prescribing Rates, 2010, CDC, available at  
 33 <https://www.cdc.gov/drugoverdose/maps/rxcounty2010.html> (last visited April 18,  
 34 2018).

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<sup>538</sup> U.S. Prescribing Rate Maps, CDC, available at  
 36 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
 37 2017).

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<sup>539</sup> U.S. County Prescribing Rates, 2009, CDC, available at  
 39 <https://www.cdc.gov/drugoverdose/maps/rxcounty2009.html> (last visited April 18,  
 40 2018).

1 100 people in 2008<sup>540</sup> and 55.1 in California,<sup>541</sup> the Tehama County rate was  
2 123.6 per 100 people.<sup>542</sup> In 2007, the national average was 75.9 opioid  
3 prescriptions per 100 people,<sup>543</sup> but the Tehama County rate was 121.3 per 100  
4 people.<sup>544</sup> Compared to a national average of 72.4 opioid prescriptions per 100  
5 people prescribed opioids in 2006,<sup>545</sup> the Tehama County rate was 109.4 per 100  
6 people.<sup>546</sup>

7 **2. The Relief Sought.**

8 767. The RICO Diversion Defendants' violations of law and their pattern  
9 of racketeering activity directly and proximately caused the County injury in its  
10 business and property. The RICO Diversion Defendants' pattern of racketeering  
11 activity, including their refusal to identify, report and halt suspicious orders of  
12 controlled substances, logically, substantially and foreseeably cause an opioid  
13 epidemic. The County was injured by the RICO Diversion Defendants' pattern of  
14 racketeering activity and the opioid epidemic that they created.

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17 <sup>540</sup> U.S. Prescribing Rate Maps, CDC, available at  
18 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
2017).

19 <sup>541</sup> U.S. State Prescribing Rates, 2008, CDC, available at  
20 <https://www.cdc.gov/drugoverdose/maps/rxstate2008.html> (last visited Dec. 11,  
2017).

21 <sup>542</sup> U.S. County Prescribing Rates, 2008, CDC, available at  
22 <https://www.cdc.gov/drugoverdose/maps/rxcounty2008.html> (last visited April 18,  
2018).

23 <sup>543</sup> U.S. Prescribing Rate Maps, CDC, available at  
24 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,,  
2017).

25 <sup>544</sup> U.S. County Prescribing Rates, 2007, CDC, available at  
26 <https://www.cdc.gov/drugoverdose/maps/rxcounty2007.html> (last visited April 18,  
2018).

27 <sup>545</sup> U.S. Prescribing Rate Maps, CDC, available at  
28 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html> (last visited Oct. 30,  
2017).

<sup>546</sup> U.S. County Prescribing Rates, 2006, CDC, available at  
<https://www.cdc.gov/drugoverdose/maps/rxcounty2006.html> (last visited April 18,  
2018).

1       768. As the County alleges, the RICO Diversion Defendants knew that the  
 2 opioids they manufactured and supplied were unsuited to treatment of long-term,  
 3 chronic, non-acute, and non-cancer pain, or for any other use not approved by the  
 4 FDA, and knew that opioids were highly addictive and subject to abuse.<sup>547</sup>  
 5 Nevertheless, the RICO Diversion Defendants engaged in a scheme of deception,  
 6 that utilized the mail and wires as part of their fraud, in order to increase sales of  
 7 their opioid products by refusing to identify, report suspicious orders of  
 8 prescription opioids that they knew were highly addictive, subject to abuse, and  
 9 were actually being diverted into the illegal market.<sup>548</sup>

10      769. Here, as the County alleges, the link of causation generally breaks  
 11 down into three very short steps: (1) the RICO Diversion Defendants' affirmative  
 12 action to continue supplying prescription opioids through legal channels with  
 13 knowledge that they were being diverted into the illicit market; (2) an opioid  
 14 epidemic in the form of criminal drug trafficking, misuse and abuse; and (3)  
 15 injuries to the County.<sup>549</sup> Although not as direct as a car accident or a slip-and-fall  
 16 case, this causal chain is still a "direct sequence" and a logical, substantial and  
 17 foreseeable cause of the County's injury.<sup>550</sup>

18      770. Specifically, the RICO Diversion Defendants' predicate acts and  
 19 pattern of racketeering activity caused the opioid epidemic which has injured the  
 20 County in the form of substantial losses of money and property that logically,  
 21 directly and foreseeably arise from the opioid-addiction epidemic. The County's  
 22 injuries, as alleged throughout this complaint, and expressly incorporated herein  
 23 by reference, include:

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 25 <sup>547</sup> *Traveler's Property Casualty Company of America v. Actavis, Inc.*, 22 Cal.  
 26 Rptr. 3d 5, 19 (Cal. Ct. App. 2017).

27 <sup>548</sup> *City of Everett v. Purdue Pharma L.P.*, 2017 WL 4236062, \*6 (W.D. Wash.  
 28 Sept. 25, 2017).

<sup>549</sup> *Id.*

<sup>550</sup> *Id.*

- 1       a. Losses caused by purchasing and/or paying reimbursements for the  
2           RICO Defendants' prescription opioids, that The County would not have  
3           paid for or purchased but for the RICO Diversion Defendants' conduct;
- 4       b. Losses caused by the decrease in funding available for The County's  
5           public services for which funding was lost because it was diverted to  
6           other public services designed to address the opioid epidemic;
- 7       c. Costs for providing healthcare and medical care, additional therapeutic,  
8           and prescription drug purchases, and other treatments for patients  
9           suffering from opioid-related addiction or disease, including overdoses  
10          and deaths;
- 11      d. Costs of training emergency and/or first responders in the proper  
12          treatment of drug overdoses;
- 13      e. Costs associated with providing police officers, firefighters, and  
14          emergency and/or first responders with Naloxone – an opioid antagonist  
15          used to block the deadly effects of opioids in the context of overdose;
- 16      f. Costs associated with emergency responses by police officers,  
17          firefighters, and emergency and/or first responders to opioid overdoses;
- 18      g. Costs for providing mental-health services, treatment, counseling,  
19          rehabilitation services, and social services to victims of the opioid  
20          epidemic and their families;
- 21      h. Costs for providing treatment of infants born with opioid-related medical  
22          conditions, or born addicted to opioids due to drug use by mother during  
23          pregnancy;
- 24      i. Costs associated with law enforcement and public safety relating to the  
25          opioid epidemic, including but not limited to attempts to stop the flow of  
26          opioids into local communities, to arrest and prosecute street-level  
27          dealers, to prevent the current opioid epidemic from spreading and  
28          worsening, and to deal with the increased levels of crimes that have

1                   directly resulted from the increased homeless and drug-addicted  
2                   population;

3                   j. Costs associated with increased burden on the County's judicial system,  
4                   including increased security, increased staff, and the increased cost of  
5                   adjudicating criminal matters due to the increase in crime directly  
6                   resulting from opioid addiction;

7                   k. Costs associated with providing care for children whose parents suffer  
8                   from opioid-related disability or incapacitation;

9                   l. Loss of tax revenue due to the decreased efficiency and size of the  
10                  working population in Plaintiffs' Community;

11                  m. Losses caused by diminished property values in neighborhoods where  
12                  the opioid epidemic has taken root; and

13                  n. Losses caused by diminished property values in the form of decreased  
14                  business investment and tax revenue.

15                 771. The County's injuries were proximately caused by Defendants'  
16                 racketeering activities because they were the logical, substantial and foreseeable  
17                 cause of The County's injuries. But for the opioid-addiction epidemic created by  
18                 Defendants' conduct, The County would not have lost money or property.

19                 772. The County's injuries were directly caused by the RICO Diversion  
20                 Defendants' pattern of racketeering activities.

21                 773. The County is most directly harmed and there is no other Plaintiff  
22                 better suited to seek a remedy for the economic harms at issue here.

23                 774. Plaintiff seeks all legal and equitable relief as allowed by law,  
24                 including *inter alia* actual damages, treble damages, equitable relief, forfeiture as  
25                 deemed proper by the Court, attorney's fees and all costs and expenses of suit and  
26                 pre- and post-judgment interest

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**COUNT V  
FALSE ADVERTISING  
Business and Professions C**

**Violations of California Business and Professions Code section 17500, et seq.**  
**(Against All Defendants)**

775. Plaintiff, The People, incorporate by reference all other paragraphs of this Complaint as if fully set forth here, and further alleges as follows.

776. This Count is brought by the People of the State. This Count is brought pursuant to Sections 17535 and 17536 of the California Business and Professions Code for injunctive relief, restitution and civil penalties.

777. Section 17500 of the California Business and Professions Code makes it “unlawful for any person, . . . corporation . . . with intent directly or indirectly to dispose of real or personal property . . . or to induce the public to enter into any obligation relating thereto, to make or disseminate or cause to be made or disseminated before the public in this state, . . . in any . . . manner or means whatever . . . any statement, concerning that real or personal property . . . which is untrue or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue or misleading.” Cal. Bus. & Prof. Code § 17500.

778. As described above in allegations expressly incorporated herein, at all times relevant to this Complaint, Defendants directly and indirectly violated Section 17500 by making and disseminating untrue, false and misleading statements about, *inter alia*, the use of opioids for chronic pain, about the risks of addiction related to opioids, about the signs of addiction and how to reliably identify and safely prescribe opioids to patients predisposed to addiction, and about their so-called abuse-deterrent opioid formulations. Defendants also repeatedly failed to disclose material facts about the risks of opioids.

779. The Manufacturer Defendants also made untrue, false, and misleading statements that included, but were not limited to:

1       780. Claiming or implying that opioids would improve patients' function  
2 and quality of life;

3       781. Claiming that opioids should be used to treat chronic pain and that  
4 there was a significant upside to long-term opioid use;

5       782. Mischaracterizing the risk of opioid addiction and abuse, including  
6 by stating or implying the opioids were rarely addictive, that "steady state" and  
7 abuse-resistant properties meant the drugs were less likely to be addictive or  
8 abused, and that specific opioid drugs were less addictive or less likely to be  
9 abused than other opioids;

10      783. Claiming or implying that addiction can be avoided or successfully  
11 managed through the use of screening and other tools and exaggerating the  
12 effectiveness of screening tools to prevent addiction;

13      784. Promoting the misleading concept of pseudoaddiction, thus  
14 concealing the true risk of addiction, and advocating that the signs of addiction  
15 should be treated with more opioids;

16      785. Mischaracterizing the difficulty of discontinuing opioid therapy,  
17 including by mischaracterizing the prevalence and severity of withdrawal  
18 symptoms, and claiming that opioid dependence and withdrawal are easily  
19 managed;

20      786. Claiming of implying that increased doses of opioids pose no  
21 significant additional risk;

22      787. Misleadingly depicting the safety profile of opioids prescribed by  
23 minimizing their risks and adverse effects while emphasizing or exaggerating the  
24 risks of competing products, including NSAIDs; and

25      788. In the case of Purdue, mischaracterizing OxyContin's onset of action  
26 and duration of efficacy to imply that the drug provided a full 12 hours of pain  
27 relief.

1       789. The Manufacturer Defendants made deceptive representations to the  
2 public about the use of opioids to treat chronic non-cancer pain. Each  
3 Manufacturer Defendant also omitted or concealed material facts and failed to  
4 correct prior misrepresentations and omissions to the public about the risks and  
5 benefits of opioids. Each Defendant's omissions rendered even their seemingly  
6 truthful statements about opioids deceptive.

7       790. Defendants' conduct was likely to mislead or deceive The People and  
8 Plaintiffs' Community, including Californians who purchased or covered or paid  
9 for the purchase of opioids for chronic pain.

10      791. Each Manufacturer Defendant has conducted, and has continued to  
11 conduct, a widespread marketing scheme designed to promote opioids and  
12 persuade doctors and patients that opioids can and should be used for chronic  
13 pain, resulting in opioid treatment for a far broader group of patients who are  
14 much more likely to become addicted and suffer other adverse effects from the  
15 long-term use of opioids. In connection with this scheme, each Manufacturer  
16 Defendant spent, and continues to spend, millions of dollars on promotional  
17 activities and materials that falsely deny or trivialize the risks of opioids while  
18 overstating the benefits of using them for chronic pain. This conduct tends to  
19 mislead or deceive, and has misled and deceived, The People and Plaintiffs'  
20 Community.

21      792. The Manufacturer Defendants have disseminated these common  
22 messages to reverse the popular and medical understanding of opioids and risks of  
23 opioid use. They disseminated these messages directly, through their sales  
24 representatives, in speaker groups led by physicians the Manufacturer Defendants  
25 recruited for their support of their marketing messages, and through unbranded  
26 marketing and industry-funded front groups.

27      793. Pursuant to Section 17535 of the California Business and Professions  
28 Code, The People request an order from this Court enjoining Defendants from any

1 further violations of the California False Advertising law, California Business and  
2 Professions Code §§ 17500 *et seq.*

3 794. Pursuant to Section 17535 of the California Business and Professions  
4 Code, the People request restitution of any money acquired by Defendants'  
5 violations of the California False Advertising law, California Business and  
6 Professions Code §§ 17500 *et seq.*

7 795. Pursuant to Section 17536 of the California Business and Professions  
8 Code, The People request an order assessing a civil penalty of two thousand five  
9 hundred dollars (\$2,500) against Defendants for each violation of the California  
10 False Advertising law, California Business and Professions Code §§ 17500 *et seq.*

11 **COUNT VI**

12 **NEGLIGENT MISREPRESENTATION**

13 **(Against All Defendants)**

14 796. Plaintiff, The County, incorporates by reference all other paragraphs  
15 of this Complaint as if fully set forth here, and further alleges as follows.

16 797. The County seeks economic damages which were the foreseeable  
17 result of the Defendants' intentional and/or unlawful actions and omissions.

18 798. California classifies negligent misrepresentation as a species of fraud  
19 or deceit for which economic losses are recoverable. *Kalitta Air, L.L.C. v. Cent.*  
20 *Texas Airborne Sys., Inc.*, 315 F. App'x 603, 607 (9th Cir. 2008) (citing *Bily v.*  
21 *Arthur Young & Co.*, 3 Cal. 4th 370, 11 Cal. Rptr. 2d 51, 834 P.2d 745, 768  
22 (1992)).

23 799. The elements of negligent misrepresentation in California are that the  
24 defendant: (1) made a misrepresentation of a past or existing material fact, (2)  
25 without reasonable grounds for believing it to be true, (3) with the intent to induce  
26 another's reliance on the misrepresentation, (4) justifiable reliance on the  
27 misrepresentation, and (5) resulting damage. *Wells Fargo Bank, N.A. v. FSI, Fin.*  
28 *Sols., Inc.*, 196 Cal. App. 4th 1559, 1573, 127 Cal. Rptr. 3d 589, 600 (2011); *Fox*

1     *v. Pollack*, 181 Cal. App. 3d 954, 962, 226 Cal. Rptr. 532, 536–37 (Ct. App.  
 2     1986). Negligent misrepresentation “encompasses ‘[t]he assertion, as a fact, of  
 3     that which is not true, by one who has no reasonable ground for believing it to be  
 4     true.’” *Small v. Fritz Companies, Inc.*, 30 Cal. 4th 167, 173–74, 65 P.3d 1255,  
 5     1258 (2003) (citing Cal. Civ. Code § 1710(2)).

6                 800. As described elsewhere in this Complaint in allegations expressly  
 7     incorporated herein, Distributor Defendants misrepresented their compliance with  
 8     their duties under the law and concealed their noncompliance and shipments of  
 9     suspicious orders of opioids to Plaintiffs’ Community and destinations from  
 10    which they knew opioids were likely to be diverted into Plaintiffs’ Community, in  
 11    addition to other misrepresentations alleged and incorporated herein.

12                 801. As described elsewhere in the Complaint in allegations expressly  
 13     incorporated herein, Manufacturer Defendants breached their duties to exercise  
 14     due care in the business of pharmaceutical manufacturers of dangerous opioids,  
 15     which are Schedule II Controlled Substances, by misrepresenting the nature of the  
 16     drugs and aggressively promoting them for chronic pain for which they knew the  
 17     drug were not safe or suitable.

18                 802. The Manufacturer Defendants misrepresented and concealed the  
 19     addictive nature of prescription opioids and their lack of suitability for chronic  
 20     pain, in addition to other misrepresentations alleged and incorporated herein.

21                 803. All Defendants breached their duties to prevent diversion and report  
 22     and halt suspicious orders, and they misrepresented their compliance with their  
 23     legal duties. Defendants knew or should have known that the representations they  
 24     were making were untrue because they did not have reasonable grounds for  
 25     believing their statements to be true.

26                 804. Defendants made these false representations and concealed facts with  
 27     knowledge of the falsity of their representations, or without reasonable grounds  
 28     for believing them to be true, and did so with the intent of inducing reliance by

1 The County, Plaintiffs' Community, the public, and persons on whom The County  
2 relied.

3 805. These false representations and concealments were reasonably  
4 calculated to deceive The County, Plaintiffs' Community, and the physicians who  
5 prescribed opioids for persons in Plaintiffs' Community, were made with the  
6 intent of inducing reliance, and did in fact deceive these persons, The County, and  
7 Plaintiffs' Community.

8 806. The County, Plaintiffs' Community, and the physicians who  
9 prescribed opioids reasonably relied on these false representations and  
10 concealments of material fact

11 807. The County justifiably relied on Defendants' representations and/or  
12 concealments, both directly and indirectly. This reliance proximately caused The  
13 County's injuries.

14 808. The causal connection between the Defendants' breaches of their  
15 duties and misrepresentations and the ensuing harm was entirely foreseeable.

16 809. As described above in allegations expressly incorporated herein,  
17 Defendants' breaches of duty and misrepresentations caused, bear a causal  
18 connection with and/or proximately resulted in the damages sought herein.

19 810. The Defendants' breaches of their duties and misrepresentations were  
20 the cause-in-fact of The County's injuries.

21 811. The risk of harm to The County and Plaintiffs' Community and the  
22 harm caused should have been reasonably foreseen by Defendants. The  
23 Defendants' conduct was substantial factor in causing The County's injuries.

24 812. The Defendants were selling dangerous drugs statutorily categorized  
25 as posing a high potential for abuse and severe dependence. The Defendants  
26 knowingly traded in drugs that presented a high degree of danger if prescribed  
27 incorrectly or diverted to other than medical, scientific, or industrial channels.

28

1 However, the Defendants misrepresented what their duties were and their  
2 compliance with their legal duties.

3       813. The Defendants failed to disclose the material facts that *inter alia*  
4 they were not in compliance with laws and regulations requiring that they  
5 maintain a system to prevent diversion, protect against addiction and severe harm,  
6 and specifically monitor, investigate, report, and refuse suspicious orders. But for  
7 these material factual omissions, the Defendants would not have been able to sell  
8 opioids.

9       814. As alleged herein, each Manufacturer Defendant wrongfully  
10 represented that the opioid prescription medications they manufactured, marketed  
11 and sold had characteristics, uses or benefits that they do not have. The  
12 Manufacturer Defendants also wrongfully misrepresented that the opioids were  
13 safe and effective when the Manufacturer Defendants knew, or should have  
14 known, such representations were untrue, false and misleading.

15       815. Because of the dangerously addictive nature of these drugs, which the  
16 Manufacturer Defendants concealed and misrepresented, they lacked medical  
17 value and in fact caused addiction and overdose deaths.

18       816. The Manufacturer Defendants made deceptive representations about  
19 the use of opioids to treat chronic non-cancer pain. Each Manufacturer Defendant  
20 also omitted or concealed material facts and failed to correct prior  
21 misrepresentations and omissions about the risks and benefits of opioids. Each  
22 Defendant's omissions rendered even their seemingly truthful statements about  
23 opioids deceptive.

24       817. The Defendants' unlawful and/or intentional actions create a  
25 rebuttable presumption of negligent misrepresentation under State law.

26       818. The County seeks economic losses (direct, incidental, or  
27 consequential pecuniary losses) resulting from the Defendants' actions and  
28 omissions.

1        819. The County seeks all legal and equitable relief as allowed by law,  
2 other than such damages disavowed herein, including *inter alia* injunctive relief,  
3 restitution, disgorgement of profits, compensatory and punitive damages, and all  
4 damages allowed by law to be paid by the Defendants, attorney fees and costs, and  
5 pre- and post-judgment interest.

## COUNT VII

# **FRAUD AND FRAUDULENT MISREPRESENTATION**

## **(Against All Defendants)**

9       820. Plaintiff, The County, incorporates by reference all other paragraphs  
10 of this Complaint as if fully set forth here, and further alleges as follows.

11        821. In California, the tort of fraud or intentional misrepresentation has  
12 five elements: ““The elements of fraud, which gives rise to the tort action for  
13 deceit, are (a) misrepresentation (false representation, concealment, or  
14 nondisclosure); (b) knowledge of falsity (or ‘scienter’); (c) intent to defraud, i.e.,  
15 to induce reliance; (d) justifiable reliance; and (e) resulting damage.”” *Small v.*  
16 *Fritz Companies, Inc.*, 30 Cal. 4th 167, 173–74, 65 P.3d 1255, 1258 (2003) (citing  
17 *Lazar v. Superior Court*, 12 Cal. 4th 631, 638, 49 Cal. Rptr. 2d 377, 909 P.2d 981  
18 (1996)).

19        822. Section 1709 of the California Civil Code provides: "Fraudulent  
20 deceit. One who willfully deceives another with intent to induce him to alter his  
21 position to his injury or risk, is liable for any damage which he thereby suffers."  
22 Cal. Civ. Code. § 1709.

23        823. Section 1710 of the California Civil Code provides: "Deceit, what. A  
24        deceit, within the meaning of the last section, is either: 1. The suggestion, as a  
25        fact, of that which is not true, by one who does not believe it to be true; . . . 3.

26 The suppression of a fact, by one who is bound to disclose it, or who gives  
27 information of other facts which are likely to mislead for want of communication  
28 of that fact.” Cal. Civ. Code. §§ 1710(1) & (3). “In California, the elements of the

1 misrepresentation torts (which are also denominated forms of “deceit”) are  
2 prescribed by statute . . . and our common law tradition.” *Bily v. Arthur Young &*  
3 *Co.*, 3 Cal. 4th 370, 414, 834 P.2d 745 (1992) (citing Cal. Civ. Code § 1710).

4 824. Defendants violated their general duty not to actively deceive, have  
5 made knowingly false statements and have omitted and/or concealed information  
6 which made statements Defendants did make knowingly false. Defendants acted  
7 intentionally and/or unlawfully.

8 825. As alleged herein, Defendants made false statements regarding their  
9 compliance with state and federal law regarding their duties to prevent diversion,  
10 their duties to monitor, report and halt suspicious orders, and/or concealed their  
11 noncompliance with these requirements.

12 826. As alleged herein, the Manufacturer Defendants engaged in false  
13 representations and concealments of material fact regarding the use of opioids to  
14 treat chronic, non-cancer pain.

15 827. As alleged herein, the Defendants knowingly and/or intentionally  
16 made representations that were false. Defendants had a duty to disclose material  
17 facts and concealed them. These false representations and concealed facts were  
18 material to the conduct and actions at issue. Defendants made these false  
19 representations and concealed facts with knowledge of the falsity of their  
20 representations, and did so with the intent of misleading The County, Plaintiffs’  
21 Community, the public, and persons on whom The County relied.

22 828. These false representations and concealments were reasonably  
23 calculated to deceive The County, Plaintiffs’ Community, and the physicians who  
24 prescribed opioids for persons in Plaintiffs’ Community, were made with the  
25 intent to deceive and induce reliance, and did in fact deceive these persons, The  
26 County, and Plaintiffs’ Community.

27

28

1       829. The County, Plaintiffs' Community, and the physicians who  
2 prescribed opioids reasonably relied on these false representations and  
3 concealments of material fact.

4       830. The County justifiably relied on Defendants' representations and/or  
5 concealments, both directly and indirectly. The County's injuries were  
6 proximately caused by this reliance.

7       831. The injuries alleged by The County herein were sustained as a direct  
8 and proximate cause of the Defendants' fraudulent conduct.

9           832. The County seeks economic losses (direct, incidental, or  
10 consequential pecuniary losses) resulting from Defendants' fraudulent activity,  
11 including fraudulent misrepresentations and fraudulent concealment.

12        833. The County seeks all legal and equitable relief as allowed by law,  
13 except as expressly disavowed herein, including *inter alia* injunctive relief,  
14 restitution, disgorgement of profits, compensatory damages and punitive damages,  
15 and all damages allowed by law to be paid by the Defendants, attorney fees and  
16 costs, and pre- and post-judgment interest.

**COUNT VIII**  
**UNJUST ENRICHMENT**  
**(Against All Defendants)**

20       834. Plaintiff, The County, incorporates by reference all other paragraphs  
21 of this Complaint as if fully set forth herein, and further alleges as follows.

22        835. Defendants have unjustly retained a benefit to The County's  
23 detriment, and the Defendants' retention of the benefit violates the fundamental  
24 principles of justice, equity, and good conscience. *Peterson v. Cellco Partnership*,  
25 164 Cal. App. 4th 1583, 1593, 80 Cal. Rptr. 3d 316, 323 (2008); *Lectrodryer v.*  
26 *SeoulBank*, 77 Cal. App. 4th 723, 726, 91 Cal. Rptr. 2d 881 (2000).

27        836. As an expected and intended result of their conscious wrongdoing as  
28 set forth in this Complaint, Defendants have profited and benefited from the

1 increase in the distribution and purchase of opioids within Plaintiffs' Community,  
2 including from opioids foreseeably and deliberately diverted within and into  
3 Plaintiffs' Community.

4       837. Unjust enrichment arises not only where an expenditure by one party  
5 adds to the property of another, but also where the expenditure saves the other  
6 from expense or loss.

7       838. The County has expended substantial amounts of money in an effort  
8 to remedy or mitigate the societal harms caused by Defendants' conduct.

9       839. These expenditures include the provision of healthcare services and  
10 treatment services to people who use opioids.

11      840. These expenditures have helped sustain Defendants' businesses.

12      841. The County has conferred a benefit upon Defendants by paying for  
13 Defendants' externalities: the cost of the harms caused by Defendants' improper  
14 distribution practices.

15      842. Defendants were aware of these obvious benefits, and their retention  
16 of the benefit is unjust.

17      843. The County has paid for the cost of Defendants' externalities and  
18 Defendants have benefited from those payments because they allowed them to  
19 continue providing customers with a high volume of opioid products. Because of  
20 their deceptive marketing of prescription opioids, Manufacturer Defendants  
21 obtained enrichment they would not otherwise have obtained. Because of their  
22 conscious failure to exercise due diligence in preventing diversion, Defendants  
23 obtained enrichment they would not otherwise have obtained. The enrichment  
24 was without justification and the County lacks a remedy provided by law.

25      844. Defendants have unjustly retained benefits to the detriment of the  
26 County, and Defendants' retention of such benefits violates the fundamental  
27 principles of justice, equity, and good conscience.

28

1       845. Defendants' misconduct alleged in this case is ongoing and  
2 persistent.

3       846. Defendants' misconduct alleged in this case does not concern a  
4 discrete event or discrete emergency of the sort a political subdivision would  
5 reasonably expect to occur, and is not part of the normal and expected costs of a  
6 local government's existence. The County alleges wrongful acts which are neither  
7 discrete nor of the sort a local government can reasonably expect.

8        847. The County has incurred expenditures for special programs over and  
9 above its ordinary public services.

848. By reason of Defendants' unlawful acts, The County has been  
damaged and continues to be damaged, in a substantial amount to be determined  
at trial.

13       849. The County seeks an order compelling Defendants to disgorge all  
14 unjust enrichment to the County; and awarding such other, further, and different  
15 relief as this Honorable Court may deem just.

## PUNITIVE DAMAGES

17       850. Plaintiffs incorporate by reference all other paragraphs of this  
18 Complaint as if fully set forth herein, and further alleges as follows.

19       851. By engaging in the above-described intentional and/or unlawful acts  
20 or practices, Defendants acted maliciously towards Plaintiffs and with an  
21 intentional disregard of the Plaintiffs' rights and the safety of Plaintiffs'  
22 Community. Defendants acted oppressively, with conscious disregard for the  
23 rights of others and/or in a reckless, wanton, willful or grossly negligent manner.  
24 Defendants acted with a prolonged intentional disregard to the adverse  
25 consequences of their actions and/or omissions. Defendants acted with a  
26 conscious disregard for the rights and safety of others in a manner that had a great  
27 probability of causing substantial harm. Defendants acted toward The County with

1 malice and were grossly negligent in failing to perform the duties and obligations  
2 imposed upon them under applicable federal and state statutes and common law.

3        852. Defendants also committed fraud by knowingly and intentionally  
4 making representations that were false. Defendants had a duty to disclose material  
5 facts and concealed them. These false representations and concealed facts were  
6 material to the conduct and actions at issue.

7       853. Defendants were selling and/or manufacturing dangerous drugs  
8 statutorily categorized as posing a high potential for abuse and severe dependence.  
9 Thus, Defendants knowingly traded in drugs that presented a high degree of  
10 danger if prescribed incorrectly or diverted to other than legitimate medical,  
11 scientific or industrial channels. Because of the severe level of danger posed by,  
12 and indeed visited upon the State and Plaintiffs' Community by, these dangerous  
13 drugs, Defendants owed a high duty of care to ensure that these drugs were only  
14 used for proper medical purposes. Defendants chose profit over prudence and the  
15 safety of the community, and an award of punitive damages is appropriate as  
16 punishment and a deterrence. Punitive damages should be awarded pursuant to the  
17 common law and Cal. Civ. Code § 3294.

18        854. By engaging in the above-described wrongful conduct, Defendants  
19 also engaged in willful misconduct and gross negligence and exhibited an entire  
20 want of care that would raise the presumption of a conscious indifference to  
21 consequences.

## RELIEF

23       **WHEREFORE**, Plaintiffs respectfully pray that this Court grant the following  
24 relief:

25        855. Entering Judgment in favor of The County in a final order against  
26 each of the Defendants;

27        856. Declare that Defendants have created a public nuisance in violation  
28 of California Civil Code Sections 3479 and 3480;

1       857. Enjoin the Defendants from performing any further acts in violation  
2 of California Civil Code Sections 3479 and 3480;

3       858. Order Defendants to fund an “abatement fund” on behalf of The  
4 People for the purposes of prospectively abating the ongoing opioid nuisance;

5       859. Order that Defendants compensate The County for damages to its  
6 property due to the ongoing public nuisance caused by the opioid epidemic;

7       860. Awarding actual damages, treble damages, injunctive and equitable  
8 relief, and forfeiture as deemed proper by the Court, and attorney fees and all  
9 costs and expenses of suit pursuant to The County’s racketeering claims;

10       861. Declare that Defendants have made, disseminated as part of a plan or  
11 scheme, or aided and abetted in the dissemination of false and misleading  
12 statements in violation of the California False Advertising Act;

13       862. Enjoining the Defendants and their employees, officers, directors,  
14 agents, successors, assignees, merged or acquired predecessors, parent or  
15 controlling entities, subsidiaries, and all other persons acting in concert or  
16 participation with it, from engaging in false advertising in violation of the  
17 California False Advertising Act and ordering a temporary, preliminary or  
18 permanent injunction;

19       863. Order Defendants to pay restitution to The People of any money  
20 acquired by Defendants’ false and misleading advertising, pursuant to the  
21 California False Advertising Act;

22       864. Order Defendants to pay civil penalties to The People of two  
23 thousand five hundred dollars (\$2,500) for each act of false and misleading  
24 advertising, pursuant to Section 17536 of the California False Advertising Act;

25       865. Awarding The County the damages caused by the opioid epidemic,  
26 and their negligent misrepresentations, fraud and deceit, including (A) costs for  
27 providing medical care, additional therapeutic and prescription drug purchases,  
28 and other treatments for patients suffering from opioid-related addiction or

1 disease, including overdoses and deaths; (B) costs for providing treatment,  
2 counseling, and rehabilitation services; (C) costs for providing treatment of infants  
3 born with opioid-related medical conditions; (D) costs for providing care for  
4 children whose parents suffer from opioid-related disability or incapacitation; and  
5 (E) costs associated with law enforcement and public safety relating to the opioid  
6 epidemic;

7       866. Enter a judgment against the Defendants requiring Defendants to pay  
8 punitive damages to Plaintiffs;

9       867. Granting The County:

- 10       1. The cost of investigation, reasonable attorneys' fees, and all costs and  
11           expenses;
- 12       2. Pre-judgment and post-judgment interest; and,
- 13       3. All other relief as provided by law and/or as the Court deems  
14           appropriate and just.

15 Dated: May 14, 2018

RESPECTFULLY SUBMITTED:

16           THE PEOPLE OF THE STATE OF  
17           CALIFORNIA, COUNTY OF  
18           TEHAMA, By Richard Stout, OFFICE  
19           OF THE COUNTY COUNSEL,  
20           TEHAMA COUNTY, CALIFORNIA,  
21           Plaintiffs

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